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THE PROBLEM OF PRIMARY LATERAL SCLEROSIS

I. S. WECHSLER,* M.D.
and
SELWYN BRODY, M.D.
New York

The syndrome of lateral sclerosis has been a subject of contention among neurologists ever since Erb first described it. Actually the spastic paralysis which bears his name was in the beginning regarded as syphilitic, but that was long before the spirochete was thought of or the Bordet-Wassermann reaction discovered. Later opinion was divided as to whether lateral sclerosis was a special entity or part of another syndrome. All neurologists conceded the existence of a familial form, but some questioned the occurrence of the syndrome in the adult on a nonhereditary basis. Gowers [1] regarded the syndrome as a disease entity; so did Oppenheim [2] and Spiller; [3] Wilson [4] did not; we do.

The reason why doubt has been cast on its existence is that lateral sclerosis may be the first, and for a long time remain the only, manifestation of what will later turn out to be multiple sclerosis, combined sclerosis or combined degeneration, amyotrophic lateral sclerosis or compression of the spinal cord. And it is, indeed, true that what at first appears to be a disorder limited to both pyramidal tracts merges sooner or later into another syndrome. To answer the question with some finality we studied the records of 61 patients who have been followed both in the hospital and in private practice for the past ten years. In all, the pyramidal tracts alone were the first to be involved, so that the tentative diagnosis of lateral sclerosis could reasonably be made. Of these 31 evolved as other syndromes and were naturally eliminated. The remaining 30 presumably persisted as lateral sclerosis for from four to ten years. They were observed from time to time and were recalled for examination when this study was begun. Only 16 returned. Reexamination showed that 13 of these persisted essentially as lateral sclerosis. These require further comment, but before taking up the discussion we should like to raise other questions which appear to be even more fundamental.

The words sclerosis and degeneration are generally used interchangeably. Indeed, all scleroses are spoken of as degenerative diseases. But what does sclerosis or degenerative mean? In essence it is a descriptive term to designate gradual disappearance of myelin sheaths, axis cylinders and nerve cells and their replacement with glia tissue. Obviously this is an end process, a necropsy diagnosis in vivo, which tells us little of etiology and less of pathogenesis. Sclerosis is no more descriptive than cirrhosis, which is another pathologic diagnosis in vivo. These convenient labels are illusory and give the impression of knowledge which we do not possess.

The conviction has gradually grown on neurologists that multiple sclerosis, of which lateral sclerosis may be a temporary manifestation, is not one disease entity but is the clinical expression of a variety of underlying factors. It is a congeries of syndromes. We now know that apparently the same "disease" may be the result of infection, probably virus, of sensitization, of vitamin or other deficiency and perhaps of vascular disease. The old quarrel whether multiple sclerosis is an inflammatory or so-called degenerative disease has lost its meaning; it is both, and more. The error lay in the fallacy inherent in generalization from particulars. Each pathologist accurately described what he saw, but he had no evidence for the conclusion that because one or more cases seemed to be inflammatory or "degenerative" in origin therefore all were.

Amyotrophic lateral sclerosis, into which "pure" lateral sclerosis may rapidly evolve, is another so-called degenerative disease. But here too we are not dealing with one disease entity. From a study of a very large series of cases we [5] have concluded, first, that there are two large groups, namely the primary and the symptomatic, and, second, that whereas the primary may represent a deficiency syndrome the symptomatic are the expression of an inflammatory, a vascular or a toxic process. They are different syndromes which look alike clinically. This fact explains why the first runs a nonremitting course to a comparatively rapidly fatal termination, while the second may linger on for five or ten years. It may also explain why some of the primary have responded to vitamin E treatment.

Some observers sought to link lateral sclerosis and even progressive spinal muscular atrophy with amyotrophic lateral sclerosis, but it is perfectly obvious that the evolution and the clinical history of each entity stamps them as separate. Limitation of the process to the pyramidal tracts, which lateral sclerosis is, results in a chronic condition lasting twenty or thirty years. The same is true of progressive spinal muscular atrophy, which is a very chronic process limited to the anterior horn cells. If, however, the pyramidal tracts and the anterior horns are simultaneously involved, the result is amyotrophic lateral sclerosis, which is a subacute syndrome terminating fatally in two or three years.

Dr. Brody is Dr. Isadore Abrahamson Fellow.
From the Neurological Service of the Mount Sinai Hospital.

Paper published under the auspices of the Section on Nervous and Mental Diseases.

1. Gowers, W. R.: A Manual of Diseases of the Nervous System, London, J. & A. Churchill, 1886, vol. 1, p. 330.
2. Oppenheim, H.: Lehrbuch der Nervenkrankenheiten, ed. 7, Berlin, S. Karger, 1923, p. 228.
3. Spiller, W. G.: Primary Degeneration of the Pyramidal Tracts: Study of 8 Cases with Necropsy, Univ. Pennsylvania M. Bull. **17**: 390-407, 1904.
4. Wilson, S. A. Kinnier: Neurology, edited by A. N. Bruce, Baltimore, Williams & Wilkins Company, 1940.
5. Wechsler, I. S.; Saperstein, M. R., and Stein, A.: Primary and Symptomatic Amyotrophic Lateral Sclerosis, Am. J. M. Sc. **208**:70-81, 1944.

REPORT OF CASES

CASE 1.—S. R., a man aged 43, in whom onset was gradual, with weakness of the legs in 1939, showed hyperactive deep reflexes, bilateral Babinski and preserved abdominal reflexes when examined in May 1944. No other pathologic signs were observed. Reexamination in April 1945 still showed limitation of the disease to involvement of the pyramidal tracts. The condition has lasted unchanged for six years.

CASE 2.—I. M., a man aged 51, in whom onset occurred in 1940 and who was first examined in May 1943, gave positive findings of hyperactive deep reflexes, normal abdominal reflexes and bilateral Babinski sign and no sensory changes or other neurologic signs. Reexamination in April 1945 showed no progression but continued limitation of signs to involvement of the pyramidal tracts. Duration has been five years. This patient had a spinal fluid protein of 60 mg. per hundred cubic centimeters.

CASE 3.—E. O'G., a woman aged 51, in whom gradual onset occurred in March 1939, showed in March 1940 the clinical syndrome of pure pyramidal tract disease, that is, only lateral sclerosis. Reexamination in April 1945 showed no signs of involvement of other structures of the nervous system except for slight impairment of position and vibratory sensation in the lower extremities. Duration has been six years.

CASE 4.—M. B., a woman aged 55, began to complain of gradually progressive weakness of the legs in 1937. She was first examined in February 1944, when she presented only bilateral involvement of the pyramidal tracts. Reexamination in April 1945 showed progressive but continued limitation of the disease to the pyramidal tracts, plus very slight impairment of vibratory and position sensation in the toes and feet. Duration has been eight years.

CASE 5.—A. DeC., a man aged 23, in whom onset occurred in 1941 with progressive weakness of both lower extremities, showed bilateral pyramidal tract disease and nothing else when examined in March 1944. No history of remissions was elicited. Reexamination in April 1945 again showed a syndrome of pure lateral sclerosis with involvement alone of the pyramidal tracts. No signs of spread or dissemination. Duration has been four years.

CASE 6.—I. F. I., a woman aged 42, in whom the condition began gradually in 1940, showed only bilateral pyramidal tract signs and no evidence of dissemination or a history of remissions when examined in January 1945 and again in April 1945. In this case there arose the question of familial incidence because the mother and a sister, who had not been examined, are said to have had sclerosis. Duration has been five years.

CASE 7.—B. F., a woman aged 36, in whom the condition set in with weakness of the legs in 1938, felt better during one pregnancy after that date, but in the main the weakness of the legs progressed. Examination in 1943 showed only bilateral pyramidal tract signs. Reexamination in April 1945 still revealed a primary lateral sclerosis. Duration has been seven years.

CASE 8.—E. P., a man aged 36, in whom the onset of the present illness dated back to 1938, which has been progressive to date, showed bilateral pyramidal tract signs limited to the lower extremities when examined in August 1944. In April 1945 he still had signs only of pyramidal tract disease. Duration of the illness has been seven years. In this case there was a history of injury to the spine in 1937, but neither then nor for a year thereafter was there evidence of disease.

CASE 9.—H. B., a man aged 49, in whom gradual onset of the illness became manifest in 1942, presented signs limited entirely to disease of the pyramidal tracts bilaterally in December 1943. The weakness and the stiffness of the legs increased, and on reexamination in April 1945 he showed only the syndrome of lateral sclerosis with pure pyramidal tract signs. Duration has been three years.

CASE 10.—R. F., a man aged 30, in whom the disease began gradually in 1933 and progressed unchanged for twelve years, was first examined in March 1941. At that time he showed only the usual signs of bilateral pyramidal tract involvement. The condition progressed without remissions. When reexamined in April 1945 he still presented signs indicative only of pyramidal tract disease. Duration has been twelve years.

CASE 11.—H. M., a woman aged 41, in whom the onset was gradual and dated to March 1941, was first seen in February 1943, when she showed bilaterally hyperactive knee and ankle jerks, absent abdominal reflexes and defective plantar responses. The disease progressed without remission. Reexamination in April 1945 showed more advanced involvement of the pyramidal tracts. There was, in addition, slight impairment of position and vibratory sensation. Duration has been four years.

CASE 12.—J. C., a woman aged 46, in whom the onset was gradual and dated back to 1938, was first examined in April 1940, showing typical lateral sclerosis with bilateral pyramidal tract signs, including the Babinski sign and absent abdominal reflexes. Reexamination in April 1945 disclosed progressive weakness and spasticity with continued limitation to involvement of the pyramidal tracts, except for slight impairment of position and vibratory sensation in the legs. Duration has been seven years.

CASE 13.—A. C. W., a man aged 49, in whom the onset was gradual and dated to July 1938, showed signs referable only to the pyramidal tracts when first seen in 1940. The condition slowly progressed. Reexamination in April 1945 showed advanced spasticity, hyperactive deep reflexes, Babinski and so on, that is lateral sclerosis, and no signs of involvement of other structures except for mild impairment of position and vibratory sensation in the legs. Duration has been seven years.

CASE 14.—H. E., a man aged 42, in whom the disease began gradually in 1940 with weakness of the legs and spasticity, showed a pure lateral sclerosis when examined in February 1944. The condition gradually grew worse. When reexamined in April 1945 he still showed only increased deep reflexes, absent abdominal reflexes and bilateral Babinski sign, with no signs of spread or dissemination. Duration has been five years.

CASE 15.—R. K., a woman aged 43, in whom the onset of the illness was gradual in 1940, when the legs had become weak and stiff, showed spasticity and weakness of both lower extremities, hyperactive tendon reflexes and Babinski sign when examined in August 1944. She grew worse as time went on. When reexamined in April 1945 the signs were still limited to disorder of the pyramidal tracts; that is, she had lateral sclerosis and nothing else. Duration has been five years.

COMMENT

From the description of the cases it is clear that the disease syndrome which one frequently observes unchanged over many years may be properly designated as primary lateral sclerosis. The rather large number of patients who have been studied over a comparatively long time justifies the inference that the scleroses are occurring with increasing frequency. What the cause may be we do not know and can only conjecture. Evidently there is a certain degree of selectivity by the noxious process, whatever its nature, and limitation to certain pathways in the spinal cord. This principle of selectivity holds true of many diseases of the nervous system. Whether or not it is the result of special properties of the noxious agents or of the varying chemical constitution of the different structures within the nervous system, the fact is that there exists selectivity of involvement. In some cases the selectivity affects only the brain or the cerebellum or the spinal cord; in others the white matter alone may be affected or the gray substance, or the anterior cells with nuclear masses in the brain; in still others only certain pathways or tracts are involved even though all appear as white matter. The same principle of selectivity holds with regard to the effects of deficiency on structures of the nervous system, as it does with endogenous or exogenous toxins, with bacterial or virus infections or other noxious agents. This is exemplified in the

combined degeneration of pernicious anemia and in vitamin B_1 deficiency. It may hold for vitamin E and possibly for others yet to be determined. It is true of protein sensitization and the rare allergic reactions seen in the nervous system.

Characteristic of disease of the nervous system is the similarity of the clinical pictures almost irrespective of the underlying cause. The manifestations are the same provided the same structures are affected. It does not matter, for instance, whether it is an infection, disease of a blood vessel, a new growth, a trauma or a so-called degenerative process which affects the corticospinal tract, say, above the medulla; the result always is hemiplegia. In large measure the same thing holds for the meninges. Whatever the infection, the result is meningitis. The onset, the course, the treatment and the prognosis vary with the etiologic factors; the clinical pictures are fairly similar.

The question has been raised whether despite the long persistence of the syndrome of primary lateral sclerosis it does not belong to multiple sclerosis just the same. Aside from the fact that multiple sclerosis is merely a convenient label, the outstanding ultimate characteristic of the syndrome is its dissemination. None of the patients herein described showed this characteristic. There was no history of transitory episodes in any of them. That a few did show slight evidence of involvement of the posterior column does not, we believe, invalidate the statement. Other authors, namely Gowers, Oppenheim and Bing, have observed similar involvement. This speaks for slight spread but not for dissemination. The same authors, and others too, have mentioned sphincter disturbances. We recorded incontinence in only 2 patients, and that rarely, but these showed clinically pure involvement of the pyramidal tracts in the spinal cord. With but 1 minor exception, all cases followed a progressive and unremitting course. Again, with one doubtful exception there was no history of familial involvement in the group under discussion.

Laboratory studies in all cases failed to throw light on the etiology but served to eliminate other diseases. The Bordet-Wassermann reaction was universally negative in the blood and spinal fluid in the patients included in this group. With 1 exception, the spinal fluid protein was normal, and there was no increase of cells. Complete blood counts and hemoglobin determinations showed no anemias or other deviations from the normal. Gastric acidity was normal in all patients.

Reverting once more to the question of selective involvement by noxious agents of certain pathways in the spinal cord, we should like to refer to lathyrism. This disease too seems to be limited to disorder of the pyramidal tracts. The lathyrus, and it is not wholly settled whether this alone is the cause, seems to have specific affinity for the corticospinal pathways in the lateral columns of the spinal cord. But despite the limitation of the disease to the pyramidal tracts, incontinence of urine is occasionally observed during the course of the illness. Minchin,[6] who mentions this, also raises the question of nutritional deficiency in lathyrism.

The apparent increase in the incidence of primary lateral sclerosis, and for that matter of other so-called degenerative diseases, raises the question of the effect of nutritional factors on the incidence of the various disease syndromes. Many observers have commented on the radical changes in the dietary habits of the population. From a bread-eating, meat-consuming people we have become a vegetable-milk-egg-cereal eating nation, with the bread and cereals one does eat made of finely milled corn and wheat products. There seems to be an increase too in the incidence of all sorts of allergic reactions. Virus infections, hitherto unrecognized, are uncovered in ever greater numbers. Finally, we see ever more benign so-called degenerative diseases syndromes. Thus, while one still observes severe and even malignant types of multiple sclerosis, one comes across as many or more typically disseminated syndromes which run a comparatively benign course. Whether the factors mentioned have explanatory validity can only be conjectured for the present.

6. Minchin, R. L. H.: Primary Lateral Sclerosis of South India (Lathyrism Without Lathyrus), Brit. M. J. 1: 253-255, 1940.

SUMMARY

Primary lateral sclerosis seems to be a distinct clinical syndrome unrelated to the other scleroses. The words sclerosis and degenerative, which are used interchangeably, may be usefully employed but only for convenient nosologic purposes. They are descriptive terms of pathologic end processes, literally autopsy diagnoses in vivo, and tell us nothing of etiology or of pathogenesis. Time alone will tell whether the scleroses represent virus infections, deficiency reactions or allergic syndromes, and only chemical, pharmacologic and pathophysiologic studies will throw light on these most obscure clinical entities. The scleroses represent syndromes which appear to be the result of the selective affinity of various endogenous or exogenous noxious agents for specific structures of the nervous system. For the present the various entities must be viewed merely as the clinical expression of anatomicopathologic syndromes of unknown etiology and pathogenesis. Neither multiple sclerosis nor amyotrophic lateral sclerosis presents a single etiologic or pathologic entity. Each consists of several different syndromes, although clinically they fall into fairly consistent groups. Amyotrophic lateral sclerosis consists of two large groups, namely the primary and symptomatic, the latter of at least three subdivisions. There seems to be an increase in the incidence of the lateral and other scleroses, that is, of the so-called degenerative diseases of the nervous system. There also appears to be an increase in the more benign types, so that, despite want of knowledge of causes, one may venture a less hopeless prognosis.

70 East Eighty-Third Street, New York 28.

ABSTRACT OF DISCUSSION

DR. FREDERICK P. MOERSCH, Rochester, Minn: The problem of primary lateral sclerosis is one that always arouses a healthy controversy among neurologists. There are those neurologists who steadfastly maintain that there is no such disease syndrome as primary lateral sclerosis, while other neurologists are willing to accept its existence. It is gratifying to have at this time in the inimitable style of the writers an authoritative analysis of their own cases of lateral sclerosis. Dr. Stark and I recently completed a similar review of our cases of lateral sclerosis, and we find that our observations and conclusions agree very closely with those of Wechsler and Brody. Whether lateral sclerosis represents a distinct clinical syndrome or is but a phase or forerunner of multiple sclerosis, combined sclerosis or amyotrophic lateral sclerosis is more than a question of academic interest. Certainly the diagnosis of multiple sclerosis continues to carry with it a seriousness, if not of immediate importance, certainly of lurking difficulties ahead. On the other hand, primary lateral sclerosis as qualified by Wechsler and Brody carries with it a much more favorable prognosis in the majority of cases. That the nervous system reacts in a rather limited manner to noxious agents is an observation of considerable importance. This observation may in a measure account for the many instances of so-called sclerosis of the cord which seemingly are the results of very diverse causes. This

observation may also aid in explaining the fact that from the clinical standpoint we are unable to differentiate the familial cases of lateral sclerosis or multiple sclerosis from the cases in which there is no familial history. Probably until we uncover the cause of these conditions we cannot hope to solve the riddle presented by these disease conditions. As stated by Wechsler and Brody, a diagnosis of primary lateral sclerosis early in the disease process carries with it considerable doubt as to its accuracy, for with the passage of time the lateral sclerosis may prove to have been the forerunner of some more widespread disease of the spinal cord or even a focal compression at some point along the spinal cord. If the affliction persists for ten or more years without evidence of dissemination or signs of focal compression of the spinal cord, the diagnosis of primary lateral sclerosis would seem to be well substantiated. Just why some mild changes in the posterior columns appeared in a few patients with primary lateral sclerosis is not clear. In our cases these findings were attributed to changes in the posterior column secondary to the age of the patient. We have not been struck with the increase in the incidence of lateral sclerosis. However, our incidence of multiple sclerosis has been on the increase, but we have attributed this to the anxiousness on the part of patients seeking some form of therapy

Dr. Henry Alsop Riley, New York: The views expressed by Drs. Wechsler and Brody are those which are accepted by the majority of neurologists at the present time. Lateral sclerosis may be a primary disease or may be the first manifestation of other system diseases such as multiple sclerosis, dorsolateral spinal degeneration, amyotrophic lateral sclerosis and myelopathies resulting from various etiologic agents. In order to make a diagnosis of primary lateral sclerosis it is necessary to follow a patient for a considerable length of time before one can be certain that the condition is limited to the pyramidal tracts and not merely the first symptom of other types of disorder. Neurologists of any experience have seen many instances of all these various combined disorders. In some instances spinal cord neoplasms may for many years present the picture only of isolated pyramidal tract disease, the other definitive symptoms appearing only much later than the development of the pyramidal tract dysfunction. It is therefore of essential importance for any patient who presents seemingly pure pyramidal tract symptoms to be followed carefully and examined at relatively frequent intervals in order that one may be sure of the continuing clinical picture. I believe that there might be some reservation raised with regard to those cases included in the group which showed involvement, minimal though it may be, of the dorsal columns as shown by the reduction in vibratory and muscle-tendon sensibility. Primary lateral sclerosis should present no sensory disturbances. The presentation of a group of patients such as Drs. Wechsler and Brody have described is of value in emphasizing the necessity for periodic neurologic examinations in order that remediable conditions may not be missed.

Dr. H. Houston Merritt, Boston: The existence of a primary lateral sclerosis as a clinical entity has been doubted by most modern neurologists. Although cases with symptoms and signs limited to those which result from injury to the pyramidal tract are not infrequently encountered, it is not uncommon, as the authors point out, for such cases to develop evidence of involvement of other parts of the nervous system and thus place the case in another diagnostic category such as multiple sclerosis, amyotrophic lateral sclerosis and spinal cord tumor. In addition, pathologic verification of this entity is lacking. Drs. Wechsler and Brody in the introduction to their study say that they believe that primary lateral sclerosis is a disease entity, but in their summary they modify this by stating that primary lateral sclerosis is a distinct clinical syndrome unrelated to the other scleroses. They state that the scleroses in general (i. e. multiple sclerosis, amyotrophic lateral sclerosis, primary lateral sclerosis) appear to be the result of the selective affinity of various endogenous or exogenous noxious agents for specific structures of the nervous system. Unfortunately none of the patients presented in their study had died and they have no pathologic data to show that the disease process was limited to sclerosis of the pyramidal tract. When one considers the fact that the posterolateral sclerosis which accompanies primary anemia was once considered a system disease but that pathologic studies have shown that the nervous system is diffusely affected in this condition, the skeptic would still conclude that neither is the existence of primary lateral sclerosis as an entity proved nor is there any satisfactory proof that various noxious agents have a selective affinity for special parts of the nervous system.

PHYSICAL RECONDITIONING AFTER RHEUMATIC FEVER

PETER V. KARPOVICH, M.D.
Randolph Field, Texas
LIEUTENANT COLONEL MERRITT P. STARR
CAPTAIN ROBERT W. KIMBRO
MAJOR CHARLES G. STOLL
Medical Corps, Army of the United States
and
CAPTAIN RAYMOND A. WEISS
Air Corps, Army of the United States

There is a great deal of diversity in AAF hospitals regarding the management of the period of convalescence after rheumatic fever. It varies from a prolonged restriction of physical activities to an early participation in special exercise which often may require a great deal of exertion. This difference in attitude regarding physical activity can be explained easily. On the one hand, it has been a medical tradition, based mainly on observation among children, that rest is an essential part of the rheumatic fever regimen not only during the active stage of the disease but also during a long period of time afterward. On the other hand, accumulated experience with rheumatic fever has indicated that this disease affects adults in a lesser degree than children, and therefore the management of the patients in the two instances may not be the same. Moreover, the present attacks on the "abuse of bed rest" in the treatment of various diseases, including those of the heart, have led to the question whether a prolonged period of physical inactivity during convalescence after rheumatic fever is beneficial or not.

The AAF convalescent policy is to recondition patients before their discharge from the hospital and to prepare them, when possible, for full or limited military duty. Therefore it is of practical importance to assess and develop to the required level the capacity of the patients for physical exertion while they are in the hospital.

The need for some practical tests for determination of the physical fitness of patients convalescing from rheumatic fever has been recognized before. Swift and McEwen [1] started physical reconditioning of patients convalescing from rheumatic fever by allowing them to sit in a stationary chair for a progressively increasing length of time. After the patients had become accustomed to sitting most of the day, they were permitted to make short walks in the ward. "The first walk consisted of about 50 feet, the second either the same amount or double that, the third about 100 feet, and then the amount is increased slowly according to the patient's response." [2] Wilson [3] described a set of arbi-

From the Laboratory of Physical Fitness, AAF School of Aviation Medicine, Randolph Field, Texas (Dr. Karpovich and Captain Weiss) and the AAF Regional Hospital, San Antonio Aviation Cadet Center, San Antonio, Texas (Lieutenant Colonel Starr, Captain Kimbro and Major Stoll).

1. Swift, Homer F., and McEwen, Currier: Rheumatic Fever, in Oxford Loose-Leaf Medicine, New York, Oxford University Press, 1938, vol. 5, p. 38(47).
2. Swift, Homer F.: Personal communication to the authors.
3. Wilson, May G.: Rheumatic Fever, New York, Commonwealth Fund, 1940, p. 412

trary tests consisting of dumbbell swinging and stair climbing. As criteria for appraising the degree of fitness she used the color of the face, the degree of dyspnea and the type of systolic blood pressure curve plotted from determinations made at frequent intervals after exercise.

Our purpose in the present study was to apply certain physical fitness tests to the patients convalescing from rheumatic fever in order to determine (*a*) how soon after clinical subsidence of the disease a patient can safely participate in physical training and (*b*) how much time is required in order to regain the degree of physical fitness necessary for limited and full military duty.

METHODS

In designing the present study it was decided to start testing the physical fitness of the patients after a two week period of quiescence of the disease, with the exceptions to be noted. Criteria for the beginning of the quiescent period were normal temperature, an erythrocyte sedimentation rate of 15 mm. or less (Westergren method), a normal electrocardiogram and the absence of arthralgia. During this period no salicylates were given. Eighty-eight patients convalescing from rheumatic fever at the AAF Regional Hospital, San Antonio Aviation Cadet Center, San Antonio, Texas, were used as subjects. These patients were at various stages of convalescence (table 1).

Because of the great variation in the length of time from the beginning of the quiescent period to the beginning of testing, all patients studied in the present investigation were divided into three groups, A, B and C.

Group A, consisting of 22 men, was living in the barracks at the beginning of this study. For these men an average of three months had elapsed since the first day of quiescence. The exact time when these patients were made ambulatory could not be ascertained from their hospital records. They had had no special physical training program. Some of them had had furloughs; some had been sent for two weeks to a convalescents' camp located in a hilly section of Texas.

Group B, consisting of 30 men, had an average of 77.3 days of quiescence before the testing and physical activation began.

Group C, consisting of 36 men, was activated after an average of 16.2 days of quiescence.

Physical Fitness Tests.—In selecting tests of physical fitness suitable for the present investigation, it was decided to use the same stepping-up tests which were used in a study conducted on patients with upper respiratory diseases.[4] However, because rheumatic fever is a more debilitating disease it seemed advisable to introduce one additional mild test which could be used as the first test.

Thus, there were three stepping-up tests used in this study:[5]

1. Preliminary test, consisting of twelve complete steps in thirty seconds, using a 12 inch bench, referred to in this study as the "12 inch test."

2. Preliminary test, consisting of twelve complete steps in thirty seconds, using a 20 inch bench, referred to in this study as the "20 inch test."

3. Progressive test, consisting in stepping on a 20 inch bench at a rate of twenty-four complete steps per minute for as long as the patient could continue but no longer than five minutes.

Scoring in Preliminary Tests.—Possible scores in preliminary tests were either "passed" or "failed." The criteria were the same for both the 12 inch and the 20 inch tests. The pulse rate with the subject sitting was taken one minute after exercise for thirty seconds and multiplied by 2. If the postexercise pulse rate was 100 or less, the cardiac reaction was considered normal on the basis of a previous investigation. If, however, muscular coordination was not good and the patient had difficulty in executing the step-ups and in maintaining the cadence, he was considered as failing, regardless of his pulse reaction.

If the patient failed the 12 inch test, he was considered a bed patient and was given an additional medical examination and then retested in a day or two. If the patient passed the 12 inch test, he was given the 20 inch test on the same day. If he passed the 12 inch but failed the 20 inch test he was allowed to be ambulatory but not allowed to take part in ward exercises and was retested one or two days later. The patient who had passed both preliminary tests was placed on the ward exercise program.

TABLE 1.—*Frequency Distribution of the Number of Patients Respective to the Length of Time Elapsed from the Beginning of the Quiescent Period to the Beginning of Testing*

	Number of Men
1 week	11
2 weeks	7
3 weeks	10
4 weeks	11
5 weeks	3
6 weeks	5
7 weeks	4
8 weeks	3
9 weeks	3
10 weeks	4
11 weeks	5
12 weeks	1
13 weeks	3
14 weeks	0
15 weeks and over	18

Scoring in the Progressive Test.—Two days after passing the 20 inch preliminary test and after having had ward calisthenics, the patients were given the progressive test. The degree of fitness was estimated by the duration of well tolerated exercise, as judged by the absence of signs of distress, and by the pulse rate taken in a sitting position for half a minute, starting one minute after exercise. The possible scores in this test (table 2) are low, fair and good. For those who scored "low," the test was repeated after three or four days depending on the soreness of the leg muscles. After the patients had scored "fair," they were tested only once a week.

Erythrocyte Sedimentation Rate.—As a matter of precaution regarding the possible untoward effect of exercises, it was decided to test the patient's erythrocyte sedimentation rate twenty-four hours after each physical fitness test. This was done because a previous investigation[6] showed that after strenuous muscular work the

4. Karpovich, Peter V.; Starr, Merritt P., and Weiss, Raymond A.: Physical Fitness Tests for Convalescents, J. A. M. A. **126**: 873 (Dec. 2) 1944.

5. Stepping technic is the same for all three tests. The subject stands in front of the bench and steps up on it with one foot and then with the other. He steps down in the same order. Four counts are used for each complete step. The stepping rate is 24 complete steps per minute. The cadence, therefore is 96 counts per minute.

6. Black, William A., and Karpovich, Peter V.: Effect of Exercise on the Erythrocyte Sedimentation Rate, Am. J. Physiol. **144**: 224, 1945.

erythrocyte sedimentation rate should return to normal within twenty-four hours.

Physical Training Program.—A detailed description is given elsewhere;[7] only essentials will be outlined here. The graded physical training program was divided into three phases officially designated as III, II and I. The relationship between the present numerical classification and the former color designation is shown in table 2 in order to avoid confusion in reading some of the references mentioned in this article.

Phase III consisted of two ten minute periods of calisthenics usually given in the ward, for which reason this phase was known also as "ward exercises." The intensity of activity during the beginning of this phase was mild, raising metabolism about 100 per cent over that at rest. By the end of two weeks exercise metabolism was increased to 600 per cent over resting metabolism.

At that time patients were reexamined, and if there was no medical contraindication they were allowed to participate in mild games either outdoors or in a gymnasium. These games were given in addition to the calisthenics; therefore the time for each period was extended to thirty minutes, which included the time of walking to the place designated for the games. This part of the third phase continued for one week.

TABLE 2.—*Scoring Table for Progressive Test*

Duration of Exercise	Pulse Rate One Minute After Exercise	Score
Below 2'	Any rate	Low
2' to 2'29"	Above 100	Low
	Below 100	Fair
2'30" to 2'59"	Above 130	Low
	Below 130	Fair
3' to 3"29"	Above 140	Low
	100 to 140	Fair
	Below 100	Good
3'30" to 3'59"	Above 170	Low
	110 to 170	Fair
	Below 110	Good
4' to 4'29"	Above 130	Fair
	Below 130	Good
4'30" to 4'59"	Above 140	Fair
	Below 140	Good
5'	Above 150	Fair
	Below 150	Good

After a patient had been in phase III for three weeks and had scored "fair" on the progressive test, with the approval of the ward medical officer he was transferred to the barracks and placed in phase II of the training program. This phase continued for four weeks and was conducted outdoors. In addition to calisthenics and games, some running was included. The time allotted was forty minutes once a day during the first two weeks and fifty minutes during the last two weeks.

Patients who were on program II for four weeks and scored "good" in the progressive test were reexamined by the medical officer and with his approval were moved to the more strenuous program, I, which lasted seventy to eighty minutes once a day during the first two weeks and eighty minutes during the last two weeks.

RESULTS

The pertinent data regarding the improvement in physical fitness of each group and the disposition of the patients at the time of their discharge from the hospital are given in table 5. It is evident that group A was in a fair state of physical fitness when the testing was started, since within an average of 2.3 days after the testing began 21 men out of 22 scored "fair" on the progressive test and 10.6 days later 20 men scored "good."

TABLE 3.—*Comparison of Functional, Numerical and Color Classification of the Patients*

Functional	Official Numerical	Color
Bed*	IV*	White*
Ward-ambulatory	III	Red Orange
Barracks	II I	Blue Green

* No exercise was given during this phase.

The average rate of improvement in physical fitness of the patients in group B was approximately the same as in group C. To score "fair" group B required 21.5 days and group C 19.1 days. To score "good" group B needed altogether 31.2 days and group C 39.9 days. This means that prolonged bed rest during the period of quiescence did not result in a noticeable physical deterioration. Such an observation is not surprising, because in an AAF hospital bed rest during convalescence is often fictional, as the patients while unobserved may indulge in physical activity to a great extent.

Not all patients reached phase I of the training program. Some of them obviously reached the limit of physical fitness at phase II. Since this level appeared to be sufficiently high for men who were not going to engage in strenuous physical work, it was decided not to hold such patients in the hospital until they scored "good" on the progressive test but discharge them from the hospital six months after the onset of rheumatic disease. These patients were able to perform efficiently limited military duty.

At the time of discharge from the hospital, only 1 patient from group A received a certificate of disability for discharge, as compared with 4 men from group B and 6 from group C.

The causes for issuance of certificates of disability for discharge are given in table 4.

TABLE 4.—*Causes for Issuing Certificates of Disability for Discharge*

	Number of Men	
Group A	1	Cardiac lesion developed during present hospitalization
Group B	2	Cardiac lesion developed during present hospitalization
	1	Old cardiac lesion
	1	Rheumatoid arthritis
Group C	1	Cardiac lesion developed during present hospitalization
	1	Old cardiac lesion
	2	Rheumatoid arthritis
	2	Duration of active phase of disease beyond 3 months

Cardiac Patients.—Altogether in the three groups there were only 6 patients who developed definite valvular changes in the heart during the active phase of the disease, and 4 patients who developed either grade II or grade III systolic murmurs, thereby being designated as possible cardiac patients.[8] Moreover, there were 4 patients who, on the day of admission to the hospital, had definite cardiac lesions which did not

7. Weiss, Raymond A.: Physical Training Program for Patients Recovering from Rheumatic Fever, Project Report No. 246, Report No. 3, AAF School of Aviation Medicine, March 10, 1945; Oxygen Consumption During Various Calisthenic Exercises, Project Report No. 246, Report No. 2, AAF School of Aviation Medicine, Nov. 4, 1944.

8. Nomenclature and Criteria for Diagnosis of Diseases of the Heart, American Heart Association, St. Louis, C. V. Mosby & Company, 1943.

change during six to nine months of disease and convalescence. A brief description of diagnostic data for these patients is given in table 6. The diagnoses were made independently by three medical officers.

All patients who exhibited abnormalities of the heart as evidenced by electrocardiogram, x-ray or auscultation were frequently reexamined by the medical officer in charge, and testing was started only when there was no evidence of an active pathologic process in the heart.

Of 14 patients with cardiac lesions (table 4) only 1 did not score "fair," and of 13 who scored "fair" only 2 did not reach the "good" level of physical fitness. It among the groups as follows: group A, 5; group B, 4; group C, 1. The numbers are too small for justifying conclusive statements. The fact, however, that the average length of rheumatic activity was longest and the duration of the quiescent period shortest in group C, in which the number of cardiac patients was the smallest, indicates that the organized graded physical training program was safe for these patients.

Clinically evident cardiac lesions in all cases with the exception of 1 (subject 8 in group B) developed before physical activation started. It is of interest that the 2 cardiac patients in group C, 1 with an old cardiac

TABLE 5.—*Summary of the Improvement in Physical Fitness of Patients in Groups A, B and C and the Decision of the Disposition Board*

						Progressive Test Score				Disposition			
						Fair		Good					
Group	Number of Men in Each Group	Number of Recurrent Cases	Number of Definite or Possible Cardiac Cases	Days of Duration of Disease	Days of Duration of Quiescence	Number of Men	Number of Days from Preliminary Test to Scoring "Fair"	Number of Men	Number of Days from Preliminary Test to Scoring "Good"	Number of Men Discharged from Hospital	Full Military Duty	Limited Duty	Certificate of Disability for Discharge
A	22	1	5	41.3	91.1	21	2.3	20	10.6	22	16	5	1
B	30	11	4	33.2	77.3	30	21.5	21	31.2	29	22	3	4
C	36	13	1	66.8	16.2	35	19.1	29	39.9	35	23	2	6
Totals....	88	..	..	....	....	86		80		86	61	10	11

TABLE 6.—*Brief Diagnostic and Physical Fitness Data on Patients Who Developed Definite (D), or Possible (P) Heart Disease During Present Hospitalization, or Who, on Admission to the Hospital, Had Valvular Lesions Which Had Not Changed by the Time of Discharge (S)*

					Days from		
Group	Subject	Diagnosis at Admission	Diagnosis at Discharge	Classification	Preliminary Test to Scoring "Fair"	"Fair" to Scoring "Good"	Disposition
A	1	Normal.....	Mitral stenosis; mitral systolic murmur, grade II	D	1	1	Certificate of disability for discharge
	2	Mitral systolic murmur, grade I	Mitral systolic murmur, grade II	D	1	0	Limited military duty
	3	Mitral systolic murmur, grade I	Aortic insufficiency; mitral systolic murmur, grade II	D	..	..	Limited military duty
	4	Mitral systolic murmur, grade I	Mitral systolic murmur, grade II	P	1	1	Full military duty
	5	Mitral systolic murmur, grade I	Mitral systolic murmur, grade II	P	1	31	Limited military duty
	6	Mitral systolic murmur, grade II	Same as at admission	S	1	0	Full military duty
	7	Aortic and mitral insufficiency	Same as at admission	S	12	56	Limited military duty
B	8	Normal.....	Mitral stenosis; mitral systolic murmur, grade III	D	8	18	Certificate of disability for discharge
	9	Aortic insufficiency; mitral systolic murmur, grade I	Aortic insufficiency; mitral stenosis; mitral systolic murmur, grade II	D	57	*	Certificate of disability for discharge
	10	Mitral systolic murmur, grade I	Mitral systolic murmur, Grade II	P	44	12	Limited military duty
	11	Normal.....	Mitral systolic murmur, grade III	P	122	*	Certificate of disability for discharge
	12	Mitral systolic murmur, grade II	Same as at admission	S	3	3	Certificate of disability for discharge
C	13	Mitral systolic murmur, grade I	Mitral stenosis; mitral systolic murmur, grade II	D	9	20	Certificate of disability for discharge
	14	Mitral systolic murmur, grade II	Same as at admission	S	18	4	Certificate of disability for discharge

* Did not make the score.

may be noted here that the individual variations in regaining and developing physical fitness could not be predicted on the basis of the diagnostic findings in the heart indicated in table 6.

There is general agreement that in the presence of carditis it is wiser to reduce the amount of heart activity, and therefore bed rest is indicated. However, since there is no method for diagnosing latent pathologic processes in the rheumatic heart a conservative physician frequently tends to suspect the existence of such a process in the heart of every patient. For this reason it was of interest to establish a relationship between early activation and the incidence of pathologic cardiac changes. From tables 5 and 6 it may be seen that the incidence of definite and possible heart disease acquired during the present illness was distributed lesion and the other with a lesion acquired during the present illness, had periods of quiescence of fifteen and twelve days respectively, whereas for cardiac patients in group B the period of quiescence ranged from sixty-seven to one hundred and forty-four days.

Erythrocyte Sedimentation Rate.—Altogether 671 erythrocyte sedimentation rate determinations were made on 88 subjects after they took the progressive test. In only 22 determinations did the rate go above 15 mm. These 22 elevations were all on 16 patients, 6 of whom were responsible for 11 of the 22 readings. It was noted, however, that these 6 men had occasional slight elevations of the erythrocyte sedimentation rate which had no relation to physical training or testing.

An attempt was made also to determine the relationship between the behavior of the erythrocyte sedimenta-

tion rate during the course of the disease and the length of time it took to regain a certain level of physical fitness during the period of convalescence. In order to combine the height and the duration of the erythrocyte sedimentation rate elevation, the erythrocyte sedimentation rate area was calculated. This was done in

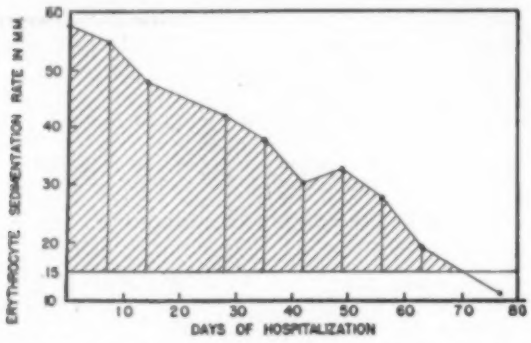

Chart 1.—Erythrocyte sedimentation rate area. The abnormal erythrocyte sedimentation rate area is represented by the shaded area, which is divided for the purposes of calculation into series of trapezoids and one triangle.

the following manner: The erythrocyte sedimentation rate was plotted on graph paper against the time in days (chart 1) and a horizontal line was drawn at the level of 15 mm. (normal erythrocyte sedimentation rate). The abnormal erythrocyte sedimentation rate area is then the area which is bound by the vertical axis on the left, the erythrocyte sedimentation rate curve above and the 15 mm. line below.

The limitation of this method is evident, because the erythrocyte sedimentation rate was determined only once a week or even less frequently. The criterion of progress in physical fitness was accepted as the time in weeks from the beginning of the period of quiescence to the scoring of "fair" on the progressive test.

For this comparison only 15 patients who received the preliminary test not later than three weeks after the beginning of the period of quiescence were used. Analysis of the data showed no significant statistical relationship between the erythrocyte sedimentation rate area and the time required to score "fair" on the progressive test because the coefficient of correlation was only 0.49, whereas in order to be significant it should be at least equal to 0.64.

COMMENT

Since in rheumatic fever greatest concern is given to a probability of cardiac damage, the tests of physical fitness employed in this study were those which emphasized cardiac function. It is realized that pulse response to an exercise is not always dependable; but, when it is combined with the observations of the actual performance in stepping up, results are gratifying. The periodic testing supplied objective evidence concerning the physical fitness of convalescents. In chart 2 are represented the records of a good and a poor recovery. The endurance time of subject A increased but little in ten weeks, and his pulse rate was high, fluctuating between 160 and 170 beats per minute. It was obvious that the degree of physical fitness of this patient was poor. At the time of discharge from the hospital he was judged to be unfit for full military duty. The duration of the stepping up (endurance time) of subject B increased in about seven weeks from forty-five seconds to five minutes, whereas the pulse rate, which had been increasing with the lengthening of endurance time for three weeks, started to slow down and continued to do so after the endurance time reached the five minute limit. This patient, at the time of discharge from the hospital, was pronounced physically fit for full military duty.

This investigation showed definitely that the testing records in most instances substantiated the judgment of ward officers and, when different, tended to cluster on the conservative side. The testing can easily be performed by a nurse, but it is worth while for the ward officer to observe the patients' progress in regaining physical prowess, which, after all, is the ultimate goal of therapeutic efforts. A prolonged bed rest ordinarily results in comparatively little rest, either physically or mentally. In the present investigation the duration of bed rest after cessation of all pathologic symptoms in group C was reduced to 16.2 days as compared with 77.3 days for group B, which was managed more conservatively. This meant that the patients had objective evidence that they were getting definitely well sixty-one days earlier. Watching their own progress in testing, they had definite proof of improvement and absence of cardiac damage. Those who developed some cardiac lesion were able to see how much work they could do and still be comfortable. The beneficial effect of the testing program on the patients' mental state cannot be minimized.

The patients in groups B and C (table 5) made the "fair" score on the progressive test in about the same length of time after testing started; yet the patients in group C had, on the average, 66.8 days of illness whereas those in group B had 33.2 days. This means that the debilitating effect of rheumatic disease is not in proportion to the length of the active pathologic process as determined by present day methods.

Only one man showed additional pathologic valvular changes during the physical training program. He, however, was detected as a "possible" cardiac patient rather early and was excused from all activities. Moreover, there is no proof that he would not have developed the same lesion if he had not participated in physical training.

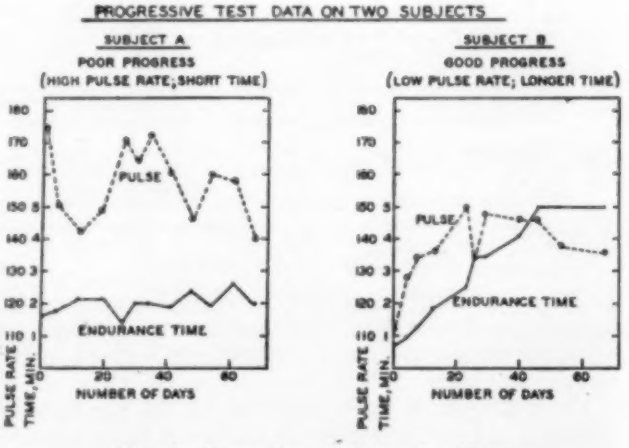

Chart 2.—Progressive test data on 2 subjects.

Observations of the erythrocyte sedimentation rate indicate that the testing, which, on most occasions, was done to the limit of the patient's stepping-up endurance, and the physical training program caused no changes which could be detected by the erythrocyte sedimentation rate. As the result of this observation, the number of erythrocyte sedimentation rate determinations in the later stages of convalescence was reduced to one every two weeks.

As a rule, patients with an erythrocyte sedimentation rate above 15 mm. were excused from the physical training program. Inadvertently, 4 patients with erythrocyte sedimentation rates ranging from 20 to 35 mm. were placed on the ward exercise program. No ill effects were observed, and the erythrocyte sedimentation rates tested two days after the progressive test were normal.

SUMMARY AND CONCLUSIONS

1. Study was conducted on 88 men convalescing from rheumatic fever in an Army Air Forces hospital.
2. Patients participated in a graded program of physical training.
3. The time of beginning and intensification of training were controlled by a series of physical fitness tests.
4. It was found that these tests constituted a simple and safe method of control over physical reconditioning of the patients and furnished objective data when a patient was brought before the Disposition Board for discharge from the hospital.
5. It was found that patients convalescing from rheumatic fever could safely participate in a graded system of physical exercises within two weeks after clinical cessation of the pathologic rheumatic activity.
6. The conventional delay in the beginning of physical reconditioning was reduced from 77.3 days to 16.2 days without causing an increase in the incidence of cardiac damage during six to twelve months of observation.
7. There was no relationship between the abnormal erythrocyte sedimentation rate area during the disease and the time necessary to obtain a "fair" score on the progressive test.

FAULTY MANAGEMENT OF PSYCHIATRIC SYNDROMES SIMULATING ORGANIC DISEASE

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Twenty years' practice of psychiatry in a general hospital and teaching of medical students have convinced me that the most important problem before our profession is the need for greater interest and more accurate knowledge about psychiatry.

Mistakes in diagnosis and treatment of patients with functional, psychoneurotic, psychosomatic or actual psychotic disorders are so common as gravely to discredit the acumen of the medical profession. These mistakes encourage patients to make the rounds of doctors and even of cultists and quacks, contribute largely to public dissatisfaction with medical care, since benefits of treatment are only temporary, and work heavy financial hardships, which help increase the clamor for some system of socialized medicine.

Recent great medical advances in surgical technics, chemotherapy and metabolic disorders have far surpassed the diagnosis and treatment of our largest group of patients, those with emotional disorders, largely because the general medical man still ignores greatly improved psychiatric knowledge and methods. Surely the psychiatric experience of this war will show medical men the necessity of requiring every graduate to know enough psychiatric medicine at least to recognize an illness as fundamentally psychic and if not himself competent to treat the illness to refer the patient for proper psychiatric treatment. Otherwise the patient is started on an endless round of medical and surgical consultations and treatments which result in eventual complete disorganization of his personality and invalidism, from which the most skilful psychiatrist cannot rescue him.

Presenting this subject so as to attract the attention it deserves is extremely difficult. Despite voluminous literature in recent years, the problem is still inadequately recognized. Physicians are so "organically minded" they fail to heed or learn.

The general physician's poor knowledge of psychiatric principles has long concerned me.[1] In 1936 with Semrad[2] I reviewed 100 cases (73 males and 27 females) of psychoneurosis admitted under diagnoses of various organic diseases to a university hospital. Of the 100 cases 72 had been mistakenly diagnosed as serious organic gastrointestinal disease, toxic hyperthyroidism, organic cerebral disease or disease of other bodily systems, and 179 surgical operations, at least half unnecessary, had been performed. Poor understanding of psychopathology and failure to obtain and evaluate adequate personal histories resulted in these erroneous diagnoses. Of the 100 patients, 70 made definite, lasting improvement under psychotherapeutic treatment.

This paper contains a detailed analysis of 150 cases selected as most typical from 500 similar cases finally treated in the psychiatric department of a general hospital. The study shows how an illness basically psychic was not recognized until it developed into a frank psychiatric syndrome. Multitudinous faulty treatments over many years for symptoms attributed to organic disease in every bodily system have been traced. When at last these patients were treated under a psychiatric discipline, relief close to dramatic in effectiveness often resulted in a short time.

OBSERVATIONS ON RECENT LITERATURE

A complete review of pertinent literature is impossible. Many excellent articles are buried in psychiatric journals and books and never found by the general practitioner or specialist who needs them most. A few recent articles are noted in support of the findings in our study.

Rennie[3] classifies into four groups patients whom the internist treats for true medical disease only to find the same complaints recurring after elimination of all reasonable medical factors: (1) those presenting some difficulty in differential diagnosis, e. g. psychogenic states confused with hyperthyroidism; (2) those with organic diseases unresponsive to therapy because serious underlying personality problems are ignored; (3) a few who call their trouble nervousness; (4) those with physical complaints not traceable to organic causes.

Evaluating the functional element in surgical cases, Donald[4] attributes mistakes in management to improper medical training and excessive emphasis on organic disease. Surgeons belittle or ignore psychic and emotional factors but overvalue laboratory tests. Too literal interpretations of basal metabolism readings or Graham

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1. Bennett, A. E.: The Role of Psychotherapy in General Medicine, J. Iowa State Med. Soc. **25**: 635-638 (Dec.) 1935.
2. Bennett, A. E., and Semrad, E. V.: Common Errors in Diagnosis and Treatment of the Psychoneurotic Patient: A Study of 100 Case Histories, Nebraska State M. J. **21**: 90-92 (March) 1936.
3. Rennie, T. A.: Relation of Psychiatry to Internal Medicine, Bull. Johns Hopkins Hosp. **65**: 265-282, 1939.
4. Donald, J. M.: Evaluating the Functional Element in the Diagnosis and Treatment of Surgical Diseases, South. Surgeon **6**: 288-292 (Aug.) 1937.

Cole tests lead to thyroid and gallbladder operations without relief of symptoms. Chronic appendicitis, migraine, spastic colitis and female pelvic complaints are surgically treated in "vain attempts to relieve symptoms of functional origin."

On the psychiatric side the Menningers [5] have long pointed out what psychologic motives induce both patients and physicians to prefer organ removals and treatments to facing the often complex emotional factors beneath the symptoms. They stress the transient, inconstant relief of such therapies.

The internist Alvarez [6] has frequently pointed out mistaken diagnoses of myxedema, diabetes, syphilis, gallbladder and pelvic disorders due to questionable laboratory findings, x-ray examinations and physical tests. Nervous constipation, not disease per se, characterizes 9 of any 10 cases of colitis, and "dropped colon is another excuse for physical treatment." Recently Allan [7] reported that nervous conditions accounted for illness in 240 of 300 patients complaining of weakness and fatigue. Positive signs to differentiate them from the 60 cases with organic disease were (1) morning fatigue, tapering off later in the day; (2) day to day change without basic physical cause; (3) immediate response to such slow acting medication as thyroid, iron and liver extracts, with (4) instant relapse on withdrawal or medication. Treatment of the psychologic cause was successful in 4 out of 5; the rest he referred to psychiatric attention.

Anxiety states with cardiac symptoms are often badly managed by the general medical profession. The symptoms are precipitated or greatly aggravated, according to Conner,[8] by doctors' comments which suggest organic heart disease or abnormality, by the patient's observation of some dramatic case, by a symptom which the patient labels as cardiac and by some protracted emotional stress. Flanders Dunbar,[9] who has helped popularize the term psychosomatic medicine to cover certain psychoneuroses, studied 1,600 hospital patients (mostly cardiac) with eight syndromes termed organic. These eight types accounted for the longest hospital stays and periods of incapacity. Psychiatric examination revealed emotional difficulties affecting the course of the disease in 80 per cent; and ten to twenty hours of psychotherapeutic attention plus the best present somatic treatment relieved symptoms in all but the most severe cases, Dunbar found.

Equally numerous are anxiety states erroneously diagnosed and treated for thyrotoxicosis. The unfortunate reliance on basal metabolic readings and trial doses of iodine only makes matters worse. Palpitation, lack of well being, loss of appetite, sensations of throat pressure and chilliness and fatigue differentiate the nervous states from borderline hyperthyroidism, Davis [10] reports. Bartlett [11] also emphasizes the rarity of such symptoms in true thyrotoxicosis: "There is no sorrier plight than that of the patient whose subjective symptoms have persisted or increased following thyroidectomy."

5. Menninger, Karl A.: Polysurgery and Polysurgical Addiction, Psychiat. Quart. **3**: 173-199 (April) 1934. Menninger, W. C.: Functional Disorders of the Gastrointestinal Tract: The Gastrointestinal Neuroses, Am. J. Digest. Dis. & Nutrition **4**: 447 (Sept.) 1937.

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7. Allan, Frank N.: The Clinical Management of Weakness and Fatigue, J. A. M. A. **127**: 957-960 (April 14) 1945.

8. Conner, L. A.: The Psychic Factors in Cardiac Disorders, J. A. M. A. **94**: 447-452 (Feb. 15) 1930.

9. Dunbar, Flanders: Psychosomatic Diagnosis, New York, Paul B. Hoeber, 1943.

10. Davis, Herbert: Borderline Hyperthyroidism, or Is It Just Nervousness? Nebraska State J. Med. **27**: 311-313 (Sept.) 1942.

11. Bartlett, Willard: Differential Conditions of Toxic Goiter from Conditions Simulating It, Mississippi Valley M. J. **63**: 96-100 (May) 1941.

PSYCHIATRIC VIEW OF MISTAKES IN DIAGNOSIS AND TREATMENT

Every experienced psychiatrist can differentiate thyroid disease from anxiety state. Careful investigation of the patient's subjective symptoms will elicit characteristic fear or panic reactions—the classic anxiety syndrome. In suspected thyroid cases psychotherapy and prolonged observation should precede medical or surgical treatment; an unnecessary thyroidectomy is a very serious error. Cases of neuroses are always made worse and sometimes incurable by surgery. In one clinic [12] no patient with thyroid overactivity is operated on without prior psychiatric evaluation of emotional factors.

The average medical curriculum, which overemphasizes organic pathologic changes and ignores mental factors as causative of gastrointestinal symptoms, is largely responsible for the many errors of internist and surgeon in gastrointestinal symptomatology. Universally mistreated are all cases of colitis or spastic constipation, invariably of psychogenic origin and symptomatic of anxiety and obsessive tensional or depressed states. Bowel-conscious patients often demand rigid medical and dietary regimens or invite appendectomies, rectal repairs or operations for adhesions. Drugs are only palliative and tend to fixate hypochondriacal ideas. Yet these patients in my experience quickly respond to strict psychiatric therapy and full nutritious diet, with small doses of insulin [13] for needed weight gain and complete avoidance of laxatives. Psychotherapy is preceded by convulsive shock therapy if depressive features are prominent.

Genitourinary complaints in neurotic persons rarely escape fallacious, tragic surgical, manipulative or medical procedures. Male patients are less frequent victims (perhaps because castration is too obvious), although the prostate gland is often blamed and treated for impotence, venereal phobias and other psychosexual problems. Purely psychiatric disorders have recently been attributed to the so-called male menopause. Female patients invariably have hysterectomies with consequent artificial menopause, uterine suspensions and curettements or cervical cauterizations for such psychogenic causes of illness as fear of pregnancy, frigidity and guilt over various psychosexual conflicts. All psychotherapeutic problems are more difficult after the tragedy of artificial menopause or other unneeded radical surgery. Too many symptomless fibroids are removed because of vague fears of uterine cancer. Retroversion never causes psychic disorders nor does uterine suspension ever relieve them, yet patients daily are told that nervousness comes from a displaced uterus—a legacy of the old concept that the wandering uterus causes hysteria.

The wholesale treatment of female patients at the menopause with estrogenic substances is also completely unwarranted except for minor symptomatic relief of actual vasomotor disturbances. In involutional psychoses sex hormones not only do not relieve but often exacerbate the disorder. Recently with Wilbur I reviewed [14] 500 case records and found that convulsive shock therapy and psychotherapy were a near specific cure in 75 cases previously treated by hormones for long periods without benefit.

12. Hannett, F., and Gitelson, M.: What Constitutes a Psychiatric Problem in General Practice? Illinois M. J. **76**: 468-475 (Nov.) 1939.

13. Bennett, A. E., and Semrad, E. V.: The Value of Insulin Treatment in Undernourished Psychiatric Patients, Am. J. Psychiat. **92**: 1425-1431 (May) 1936.

14. Bennett, A. E., and Wilbur, C. B.: Convulsive Shock Therapy in Involutional States After Complete Failure with Previous Estrogen Treatment, Am. J. M. Sc. **208**: 170-176 (Aug.) 1944.

The common excessive use of sedation by most physicians to relieve nervous disorders must be sharply condemned. Frequently abuse of these drugs by emotionally unstable patients leads to toxic encephalitis and other severe delirious reactions. In our psychiatric department sedatives are not used except the first night of admission. Barbiturates, bromides or other anesthetic agents do not relieve personality disorders and are simply a form of chemical restraint; their use betrays the physician's ignorance and inability to cope scientifically with personality diseases.

PAST MEDICAL AND SURGICAL HISTORY OF 150 CASES

Of the 150 patients in this study, 121 were female, 29 male. Previous medical and surgical treatments are grouped as far as possible into systems according to symptoms and diagnoses. A large proportion of treatments were illogical, ill advised and often detrimental to the basic personality problem.

121 Female Cases

1. *Gastrointestinal System.*—Thirty-six patients had had extensive medical and dietary therapy or prolonged diagnostic studies for varied types of colitis or spastic constipation, 7 for "intestinal flu," 10 for hemorrhoids or other rectal conditions and 50 for gastric complaints, ulcers, acid stomach, nervous indigestion, gallbladder disease or cancer phobias. A total of 111 patients, many treated for more than one condition, had thus been treated for gastrointestinal disease instead of nervous disorders.

2. *Endocrine System.*—Suspected endocrine disorders were next in frequency. For pelvic complaints 53 women received diagnosis and treatment (mostly hormones), 21 for thyroid disease and 14 had extensive liver, iron or other glandular injections for what were actually emotional symptoms. Of the 121 cases, 88 were at some time falsely considered to be endocrine disorders.

3. *Genitourinary System.*—Sixteen patients were medically treated for such pelvic diseases as tumor, cervical ulcerations, vaginal infections or uterine displacements and 15 for urinary frequency, floating kidney or bladder symptoms; a total of 31 patients (not including surgical cases) erroneously treated for disease of this tract, although the psychiatric survey and response to therapy clearly showed the psychogenic basis of their symptoms.

4. *Cardiovascular System.*—Thirty-nine patients had extensive diagnosis or actual treatment for organic heart disease, cardiac irregularities and high or low blood pressure states as causes of their nervous difficulties.

5. *Eye, Nose, Throat and Mouth.*—Five women were treated for ocular disorders and 6 had full dental extractions to relieve nervousness; despite incomplete data on other treatments (not including surgery) their numbers are great, as I have shown elsewhere.[15]

6. *Miscellaneous Medical and Cultist Therapies.*—Fifty-seven patients had long periods of bed rest, often in hospitals, and extensive doses of vitamins or tonics for vague infections such as arthritis, suspected tuberculosis or obscure focal involvements; 31 patients got excessive sedation, of whom 3 had chronic bromide intoxication, as shown clinically and by bromide blood level estimations; 58 had gone to cultists, mostly chiropractors, osteopaths, physiotherapists and Christian scientists, while only 17 of the entire 121 women had had previous psychiatric diagnosis or treatment.

7. *Surgical Treatment.*—In the past histories of the 121 women 205 operations were found; 159 were major—84 pelvic, 40 appendectomies, 11 gallbladder, 16 thyroids, 5 postoperative adhesions and 3 kidney; 46 were minor—21 rectal, 24 tonsils and nasal sinuses and 1 for varicose veins. As compared with medical therapy it was harder to determine from the standpoint of organic pathology how many of these operations were necessary. But a large percentage were accepted by patients with the understanding or at least hope of relief from nervousness; certainly none were indicated from this point of view.

29 Male Cases

1. *Gastrointestinal System.*—Fifty-five instances of prior medical or dietary treatments for bowel, stomach or gallbladder complaints were listed. Several patients had undergone varied treatment programs for what was actually psychiatric illness.

TABLE 1.—*Summary of Therapies Prior to Psychiatry*

	Total Number of Medical Treatments	Total Number of Surgical Treatments	Total Number of Treatments by Cultists and Others	Total Number of of All Treatment
Females (121).....	368	205	58	631
Males (29).....	128	39	13	170
Total (150).....	496	244	71	811

2. *Genitourinary System.*—Seven men were treated for prostatic or local genital or bladder complaints, although the etiology was a venereal disease phobia or psychosexual conflict.

3. *Endocrine System.*—Twelve patients had sex hormones, thyroid or other hormonal injections for symptoms considered of endocrine origin but actually related to sexual maladjustments.

4. *Cardiovascular System.*—Twelve patients were treated for organic heart disease, 6 with long rest periods and digitalis therapy.

5. *Miscellaneous.*—Sixteen men were treated for headaches or vague nervous complaints referred to eyes, nose, throat and mouth; 22 patients were given rest periods, tonics or serum injections for rheumatism, tuberculosis and other supposed infections; 2 patients had long periods of treatment in a Veterans Administration facility; 8 patients had excessive sedation without benefit to the nervous symptoms, and 13 men at various times received extensive treatments from cultists.

6. *Surgical Treatment.*—Thirty-nine surgical operations were performed on the 29 men, fourteen being major and twenty-five minor procedures. The former included appendectomies, cholecystectomies or stomach operations; the minor were nasal, tonsil or rectal operations. Again, one can only surmise how many were necessary, but certainly none were indicated to relieve a psychiatric disorder.

15. Bennett, A. E.: Neurologic Problems in Ophthalmology and in Rhino-Otolaryngology, Arch. Otolaryng. **18**: 260-280 (Sept.) 1933.

Psychiatric Study of the 150 Cases

Diagnoses of the 121 cases have been classified as shown in table 2.

TREATMENT PROCEDURES AND RESULTS

Treatment of these cases was carried out under a strict psychiatric regimen. A detailed psychiatric history with personality background covering lifetime data was obtained from both the patient and the closest informant. Complete physical, neurologic and laboratory investigations included a special assessment of nutritional factors. Routine psychiatric management and specific procedures, depending on the individual personal factors, were aided by psychiatric nursing and occupational and recreational therapy under specially trained personnel. Psychotherapy and bibliotherapy were preceded in cases showing predominant depressive symptomatology with curare electroshock treatments.

The average hospital stay was about five weeks; the minimum was four and the maximum eight weeks in cases with shock therapy. During the active treatment phase complete isolation of patients from family and friends is routine, but outside contacts are permitted during convalescence.

TABLE 2.—*Classification of Diagnoses*

	Women	Men
Neuroses		
Anxiety (psychoneurotic) depression	12	3
Psychoneurosis, anxiety states and hysteria	29	6
Chronic invalidism, with pronounced hypochondriasis	3	2
Obsession-compulsion	2	..
Psychoses		
Reactive depression	19	7
Manic depression	15	10
Involutional melancholia	28	1
Schizophrenia	3	..
Total	121	29

TABLE 3.—*Results of Psychiatric Treatment in 150 Cases* *

	Women	Men	Total
Full recoveries	70	10	80
Social recoveries	18	10	28
Relapses (fairly good later adjustment in 14)	18	4	22
Unimproved	7	4	11
Unknown	8	1	9

* Because of limitation of space, illustrative case histories have been omitted. These are included in the reprints, which will be sent to all those interested.

Results of treatment, one must remember, concern the worst examples and not the average run of cases, since from 500 consecutive psychiatric admissions 150 were purposely selected for more detailed study in order to typify the grosser examples of faulty management in what were essentially mental illnesses.

Of the 150 cases 70 women and 10 men after follow-up reports over one to eight years were classified as full recoveries, with good insight into their psychogenic disorders and with sustained efficiency unimpaired by neurotic conflicts masked as somatic complaints. They did not begin again to canvass the round of therapies. Social recoveries included 18 women and 10 men; these were able to adjust fairly well but were still handicapped by such emotional factors as residual anxiety or emotional depression. In many instances they continued to be problems for family and friends. Recurrent attacks or relapses were noted in 18 women and 4 men, of whom 14 later made a fairly good readjustment. The 7 unimproved women and 4 men were failures; results are unknown in 8 women and 1 man.

The psychiatric patient is often given unscientific advice. One woman in a deep depression was told by a diagnostic clinic "Go home and forget yourself or take a trip." A vacation was advised for a manic depressive man unable to work for many months. A woman with cancer phobia and obsessive ideas of orderliness was given a diet for arthritis, another for gallbladder and a smooth diet for spastic colon "that made three sheets and when I put them together," she said, "there was nothing left for me to eat and I got panicky." In a woman with involutional melancholia the pudic nerve was blocked with alcohol to relieve masturbation; a necrotic slough of the vulva resulted. For a $150 fee a psychoneuritic depressed patient had "the clitoris unhooded to relieve partial frigidity."

Frequently we read reports from clinics and other diagnostic examinations in which all tests are normal. The closest the illness is described as psychiatric is to call it nervousness, but the patient is told nothing of psychiatric treatment.

Our information from patients and relatives emphasized how after each operation the patient got a little better; then, after the hysterectomies, "the same aches and pains returned." Hormone injections, tonsillectomies, bed rest or violet ray therapy made the patient "feel better and take a little more interest," but in a few months the patient was again despondent.

The effectiveness of psychiatric treatment in our cases was shown by the degree of lasting insight and continued rapport. Patients reported better efficiency in work, more consistent good health and enjoyment of life, since they were able to deal understandingly with their symptoms. Many expressed deep gratefulness for learning how to control their nervous spells, how to adjust to disappointments and misfortunes and how to cope directly with the mechanisms and tensions which had caused their symptoms.

PSYCHIATRY AND MEDICAL EDUCATION

Fundamentally the mistakes of diagnosis and treatment that have just been discussed are due to the failure of psychiatric education. The war has helped physicians to realize this lack. Medical officers have found that their greatest hospital problem is the functionally ill soldier with often additional organic factors —the so-called psychosomatic syndrome. Undoubtedly many medical officers will return to civilian practice with a keener appreciation of estimating personality factors along with physical signs in order to arrive at a complete diagnosis of a disability. Most of the older doctors cannot be changed in their mistaken concept of psychiatric medicine.

Before a new program can function, medical college teaching and curriculums which emphasize the organic approach and blind the student to all problems not readily explained in terms of bodily disturbances, anatomic anomalies or infections must be reformed. The negative attitude to a psychologic approach must go. The medical curriculum should begin, preferably in the premedical stage, to emphasize the relationship of human personality, constitutional makeup and hereditary pattern to development of disease in the individual. The freshman medical year should link organic anatomy with so-called normal personality (psychobiology), including the influence of childhood training on adult patterns. Psychopathology (including the minor psychoses, as important causes of human maladjustment) should accompany organic pathology and physiology in the

sophomore year. Students must learn an accurate method of psychiatric history taking. Perfecting a satisfactory approach to the patient's personal conflicts and understanding his attitudes are probably the most difficult and neglected phase of medical instruction. Whitehorn [16] has supplied an admirable guide for comprehensive history taking, of use to all medical practitioners.

In the junior year should come intensive clinical clerk service, with ward contacts and outpatient studies of the common psychoneurotic reactions, especially psychosomatic syndromes, in order to apply technics learned in the sophomore year. This leaves the senior year for advanced psychotic disabilities and finally for a systematic course in elementary psychotherapy with individual case studies by each student supervised by the chief of service in seminar discussions.

Every accredited internship should require a reasonable period of training and experience in the management of psychiatric problems.

Students must learn to make positive diagnoses of neurotic illness on the evidence of emotional signs; not as at present after long and often costly procedures to exclude organic signs.[17] They must also learn that neurotic persons may have organic pathologic changes and the disabling factors must be evaluated as organic, functional or mixed. That is, the student must learn to treat both the personality and the somatic disorder.

All this means that medical schools must require better psychiatric teaching in order to attract good students and overcome the general antagonism against psychiatric medicine. Psychiatric terminology must be simplified where possible and made understandable; the student must be taught to think in terms of feelings as well as mentations. Most necessary is instruction in the art of mental healing—the affective varied methods of concrete therapy in psychiatry—with proof that the vast majority of patients can be rehabilitated and restored to usefulness. All students respond with keen interest to successful therapy. Too many have outdated notions that psychiatry deals only with dilapidated custodial cases.[18]

Above all, medical men must learn that psychoneuroses and psychoses are mental illnesses not secondary to physical disease and that no form of rest cure, drug therapy, surgery or any approach directed to treating an emotional problem at a physical level is scientific. The sick man becomes the "forgotten man" in face of the battery of diagnostic and therapeutic tests, like a guinea pig in physiologic experiments. Medicine is still an art but is to be applied scientifically. The doctor-patient relationship has been made a better tool by recent scientific discoveries. On this new scientific basis the art of the practice of medicine must be reintroduced. The sick man's personality must be judged along with the physical and laboratory data. When the evidence points to emotional and social maladjustment we must treat mental illness and thus avoid discredit to the profession.

The problem is far too great for psychiatric specialists alone. No man in medicine is wise enough to comprehend what he daily beholds. The medical practitioner of the future will have to become psychiatrically minded.

16. Whitehorn, J. C.: Guide to Interviewing and Clinical Personality Study, Arch. Neurol. & Psychiat. **52**: 197-216 (Sept.) 1944.
17. Zilboorg, Gregory: Some Physical Aspects of Mental Disease, New York State M. J. **35**: 707 (July 15) 1935. Fremont-Smith, M. Psychoneurosis—A Dangerous Diagnosis, Internat. Clin. **2**: 187 (June) 1937.
18. Menninger Foundation Report and personal study of Karl Menninger, Annual Report, Topeka, 1944.

SUMMARY

Faulty medical and/or surgical treatments were compared with modern psychiatric treatment in a detailed study of 150 psychoneurotic and psychotic patients. This study and pertinent citations from the literature indicate that the general medical profession fails to recognize and treat properly mental illness. The result is a tremendous army of maladjusted persons going from doctor to doctor and receiving illogical medical and surgical therapies that only aggravate their personality problems.

Proper psychiatric treatment is shown to result in social rehabilitation of the great majority of patients. Unfortunately, years of invalidism usually precede such treatment because of the bad professional attitude toward psychiatry.

The fundamental cause of these mistakes is failure in medical schools to emphasize properly pyschiatric education. Correction of this defect necessitates a complete change in medical curriculums and teaching. The entire problem is too great for psychiatrists alone; all physicians of the future will have to practice some psychiatric medicine.

ABSTRACT OF DISCUSSION

DR. WALTER C. ALVAREZ, Rochester, Minn.: This is a valuable paper with a message for every practicing physician. No internist with psychiatric interest can help feeling distressed as day after day he sees the unfortunate results of the handling of patients with neuroses and psychoses by physicians who took their diagnoses ready made from the reports of laboratory girls and roentgenologists and by surgeons who expected to make a diagnosis after opening the abdomen. I agree with Dr. Bennett and Mrs. Engle that if "organically minded" physicians are ever to be taught to recognize and properly treat the neuroses and psychoses the new gospel must be preached so vividly and interestingly that many will stop to listen and to read. That weird jargon which so many psychiatrists affect will never do the trick. The writers will have to use short words and homely speech, and they will have to publish often in nonpsychiatric journals. Any good physician will sense that something is nervously wrong with a psychoneurotic patient, but unfortunately few know the common neuroses and psychoses so well that they dare diagnose them positively from the history. This leads often to disaster because the minute some laboratory girl says that the patient's blood weakly agglutinates Brucella abortus or the roentgenologist says that the appendix looks diseased the really correct hunch is abandoned, and a wrong diagnosis is made and treated. A statement of Dr. Bennett and Mrs. Engle which delights me is that the psychoneuroses are mental illnesses *"not secondary to physical disease"* (italics mine). I assume that the authors are thinking of physical disease below the neck. I long have begged assistants to remember that patients have a brain, and that it has many diseases and, certainly, many diseases all its own. Today we physicians are so un-brain-minded that when a man drops dead every one says he had a heart attack. That he might just as well have had a stroke rarely occurs to any one. I mention this just to show how huge a blind spot we physicians have when it comes to disease of the nervous system.

DR. R. P. MACKAY, Chicago: There can be no doubt that the misdiagnosis and mismanagement of the so-called functionally ill patient is the medical scandal of the day. This well reasoned study properly emphasizes what is only too obvious to every thoughtful observer. It is literally true that most of our patients are improperly handled, suffer needless prolongation of their illnesses and often fall into the hands of ignorant quacks. I agree that medical education is partly to blame. Other reasons, however, are inescapable. The most important is the laziness of the physician who neglects the laborious but indispensable taking of the personal and social history. This must be done by the doctor himself; it dare not be assigned to a nurse or junior assistant. Furthermore, the physician must

talk less and listen more and must watch for the patient's subtle reactions as he is quizzed. He must elicit the outlines of his life story, his work, his play, his ambitions and his failures, his sexual and emotional appetites and his dissatisfactions. These are quite as important as the chronologic narrative of his symptoms. Next to laziness is the physician's lack of imagination. Blinded by a worship of chemical and technical procedures (which inordinately increase the cost of medical care) he forgets that patients are people who in infinitely complex ways become entangled in the emotional snarls of life. It is not enough to know that a woman has palpitation; it is necessary to discover that, for example, she has it during her husband's absence and to imagine what disturbing desires she may have, from which his presence protects her. Human sympathy is the good doctor's indispensable attribute. He can never win confidences if he is impatient or disinterested or in a hurry to go golfing or hostile because the symptoms are "ridiculous and unreasonable." There is nothing unreasonable in medicine. Tolerance and sympathy establish that rapport which reveals the diagnosis and actually works the cure. These things—industry, imagination and sympathy—with a hunger for that truth which cannot be seen in the test tube or x-ray film must be added to a sound education in psychology. Thus equipped, the practitioner becomes a wise physician who understands human beings and who, furthermore, is a human being himself.

Dr. Karl A. Menninger, Topeka, Kan.: Dr. Bennett and Mrs. Engle have done a very courageous thing. The information is known not only to psychiatrists but to many medical men and surgeons who have been just as distressed about it as any one. What to do about it is not so well known, and many will be particularly grateful for the practical and concrete suggestions. Dr. Bennett and Mrs. Engle have documented the declaration that many patients are being treated ineffectually and in some instances definitely harmfully through ignorance on the part of members of our profession of the nature of psychiatric illness. The fact, for example, that 150 psychiatric patients should have had a total of 496 courses of medical treatment and 244 courses of surgical treatment (to say nothing of treatments by cultists and others) prior to the time that their illnesses were diagnosticated as psychiatric in nature is a startling and disturbing report. The fact that a consecutive series of patients consulting one representative psychiatric clinic had averaged more than two operations each prior to their coming for psychiatric treatment is more evidence in the same direction. Serious and alarming as such statistical evidence is, it would be unfair to conclude that all of these patients had been incorrectly diagnosed or incorrectly treated. The authors themselves point out that many of these patients demanded the type of treatment they received, and this same point has been made by myself and others. The fact that the treatment given prior to the establishment of a psychiatric diagnosis and the institution of psychiatric treatment did not cure them, whereas the latter did cure them, is eloquent evidence of this. It is indeed high time that the medical profession came to recognize more generally the simple fact that the first, and often the chief, manifestation of psychiatric illness may be a somatic symptom or sign. Dr. Bennett and Mrs. Engle have submitted evidence of something which remains corridor and cloakroom and convention hall talk among psychiatrists and which is rarely brought out into the open in medical literature. Psychiatric treatment is still considered by too many medical men as a luxury, and psychiatric principles as ephemeral and inconsequential. Even the plain hardboiled facts of military statisitics have not convinced them. An article like this, with statistics of previous treatment, statistics of results after psychiatric treatment and case history illustrations is hard evidence to contradict. As a fellow psychiatrist, I want to register my admiration of the courage and directness of the authors even though I may have some slight misgivings about the excellent recovery rate reported as a result of psychiatric treatment, since it is certainly better than anything that I can report from my own experience.

Dr. A. E. Bennett, Omaha: I am pleased that the discussers agree with us as to the fundamental importance of faulty diagnosis and mismanagement of psychiatric illnesses. I particularly like Dr. Alvarez's emphasis that more psychiatrists must speak and write in simple, vivid language for nonpsychiatric practitioners. In this field Dr. Alvarez has written widely and Dr. Menninger has rendered great service both by his books and articles and by his clear, factual talks to medical students in many Eastern and Midwestern medical schools. Of course, some scientific terms will not be clear to the specialist in another field, but these terms can be explained when used and reduced to a minimum. With Dr. Mackay I agree that the physician's laziness and unimaginativeness account for improper handling of many patients, especially in history taking. I should still lay this blame on medical education because I believe that few physicians can be induced to change their methods after they have been trained in medical school to rely on laboratory and technical findings only. In documenting our cases I realized the danger of trying to evaluate too strictly the patients' past treatments. However, it is clear that many somatic conditions are overstressed and treatments given with assurance or at least hope of relief from disorders which physical procedures cannot benefit. In tabulating our recoveries after psychiatric therapy we should emphasize that we were concerned mainly with the patients' readjustment to normal work and social contacts. From that angle about half made good recoveries. Many were true depressions that respond well to shock therapy. Those considered as social recoveries are not changed basically in their personality and may be subject to periodic recurrences of their illnesses.

VITAMIN D INTOXICATION WITH METASTATIC CALCIFICATION

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The fact that irradiated ergosterol in sufficient dosage may produce toxic effects in both experimental animals and man was recognized soon after the discovery by Hess, Weinstock and Helman [1] and by Steenbock and Black [2] that the irradiated sterols possessed antirachitic properties. It has been demonstrated repeatedly that experimental animals can be killed by sufficiently large doses of this product and that the outstanding pathologic finding in these animals is diffuse metastatic calcification involving chiefly the arterial vascular system and the kidneys. That these advanced changes can also occur in the human being and lead to death is not as well known. Because of the increasing tendency for the use of large doses of vitamin D in the treatment of a variety of conditions, it was felt worth while to report a fatal case resulting from the use of this drug and to review 5 previously reported cases of metastatic calcification in man resulting from its use.

Although the number of cases in the literature in which vitamin D may have played a part in the production of abnormal calcification or death exceeds this number, only 5 of the cases were considered to be sufficiently clearcut to warrant their special consideration. In these cases postmortem examination was performed and no other obvious explanation for the abnormal calcification was determined. In 6 additional cases vitamin D intoxication could be considered to play a part. Of those cases the diagnosis in 2 [3] was based

1. Hess, A. F.; Weinstock, M., and Helman, F. D.: The Antirachitic Value of Irradiated Phytosterol and Cholesterol, J. Biol. Chem. **63**: 305-308, 1925.
2. Steenbock, H., and Black, A.: Fat Soluble Vitamins: XXIII. The Induction of Growth Promoting and Calcifying Properties in Fats and Their Unsaponifiable Constituents by Exposure to Light, J. Biol. Chem. **64**: 263-298, 1925.
3. Eisler, F.: Schwere Gefäszveränderungen bei einem 7 jähr Mädchen nach übermässigem Gebrauch eines Ergoster-inpräparates, Klin. Wchnschr. **9**: 1846, 1930. Thomasen, E.: Arterienverkalkung bei einem 8 jähren Knaben. Nach Behandlung mit Vitamin D? Acta med. Scandinav. **93**: 505-511, 1937.

solely on abnormal vascular calcification detected by roentgenographic examination. Two cases [4] showed changes in the postmortem examination that were considered to be due to intoxication with cod liver oil, but there was no pathologic calcification. The 2 remaining cases are of special interest in this study because the condition occurred in adults; these will be mentioned in more detail. A man aged 59 with Paget's disease who was the subject of a report by Wells and Holley [5] was given 5 million U. S. P. units of viosterol in fifteen days. He died of pneumonia two months later and the postmortem examination showed extensive metastatic calcification in the pulmonary alveolar walls, pulmonary veins, renal tubules, renal arteries, endocardium, stomach and skin. The authors considered that the massive vitamin D administration was in part responsible for the pathologic calcification but felt that in Paget's disease there might be also an increased ease of mobilization of calcium from the bone and more tendency for deposition to occur in the tissues. A second case in which vitamin D intoxication seemed to play a part in the death of an adult is mentioned by Kerr in discussing a paper by Freyberg, Grant and Robb [6] in 1936. He reported the case of an elderly physician who by mistake had taken 2.3 million units of irradiated ergosterol daily for eighteen days and died with the typical symptoms of vitamin D intoxication. There is no report of postmortem findings, so that it is not known whether metastatic calcification occurred.

Of the 5 previously reported cases of vitamin D intoxication characterized by metastatic calcification (as shown in the table) this was considered to be the primary cause of death in 4. In the fifth [7] the pathologic findings due to the vitamin D intoxication were considered to be incidental.

In 1929 Putschar [8] reported that a boy aged 5½ months was given 6 drops of Vigantol daily from the tenth week after birth until death at 163 days of age. This represents a daily dose of 2.2 mg. of irradiated ergosterol per day, or a total of 210 mg. This amount is less than is usually recommended for the treatment of rickets. Between the fiftieth and the seventieth day of Vigantol administration leukocytes and traces of albumin appeared in the urine. The child developed hyperpyrexia and died. Postmortem examination showed calcium deposits in the kidneys, chiefly in the renal tubular epithelium and basement membrane and to a lesser extent in the lumen of the tubules of the medulla close to the cortex. No other organs showed pathologic calcification.

Thatcher [9] reported 2 cases. The first (1931) was that of a white boy aged 18 months who had been fed an inadequate diet. For five months prior to his hospital admission he had been given 4 teaspoons of irradiated ergosterol emulsion per day, an amount of vitamin D said to be about twice the "curative" dose (the actual potency of the drug was not given). This treatment had been administered during the summer months when sunlight was abundant. The complaints on admission were weakness, anorexia and refusal to take food. The urine contained erythrocytes, leukocytes, occasional granular casts and a "moderate amount" of albumin. The patient became dull and apathetic, had hyperpnea and increasing fever and vomited several times. The blood urea reached 90 mg. per hundred cubic centimeters before death occurred twelve days after admission to the hospital. There was diffuse deposition of calcium in the medullary portion of the kidney, chiefly in the lumen of the collecting tubules. No calcium was found in the myocardium. The aorta and other arteries showed no macroscopic calcium deposits but were not examined microscopically.

Thatcher's second patient (1936), a boy aged 11½ months, was admitted to the hospital because of failure to gain weight, asthenia, anorexia and constipation. The milk intake of the infant had been made as adequate as possible and he had been exposed to sunlight during the summer months. Three weeks before death he had been given two treatments with an ultraviolet lamp. In addition he was given 1 to 2 Gm. of cod liver oil containing 200 international units of vitamin D per gram three times a day on many days. The vitamin D dosage is rather indefinite but seems to have been between 400 and 1,200 international units per day for at least four months. The patient continued ill, convulsions developed and he died. The urine contained only a trace of albumin and 4 leukocytes per high power field but no erythrocytes or casts. At postmortem examination calcium could be seen grossly as a line of gray, granular material deposited at the base of the medullary pyramids. Microscopic examination showed most of the calcium to be in the lumen of the tubules, but there was some calcification of the cells lining the tubules and a few glomeruli contained small calcium deposits. There was no calcium in the heart, arteries or other organs.

In 1939 Ross and Williams [10] described 4 cases in infants showing toxic symptoms from large doses of vitamin D. In this group there were two deaths and one autopsy. The exact age of the infant on whom the postmortem examination was done is not recorded; the ages of the group ranged from 8 to 14 months. The amount of irradiated ergosterol given is likewise not definitely known but was between 20,000 and 40,000 international units per day of the proprietary preparation "Ostogen." The child on whom a postmortem examination was performed was one of twins who had received large doses of this preparation. Both children had bronchopneumonia at the time of death. The postmortem examination revealed widespread metastatic calcification. There was calcification of the inner layer of the media of the arteries in the cardiac muscle and in the kidneys, especially in the tubules. Calcium was deposited in the lining of the pulmonary alveoli and bronchi, in the stomach muscularis and in the basal portion of the gastric mucosa cells. It was considered that the twin likewise suffered from vitamin D intoxication; roentgenograms of the long bones substantiated this opinion.

Wolf [7] attempted to determine the level of toxic dosage of an electrically activated vitamin D preparation [11] by administering massive doses to a 4 months old infant afflicted with spina bifida and a meningomyelocele. A dose of this preparation consisting of 300,000 U. S. P. units of vitamin D was given in milk daily for two weeks. Regurgitation occurred on three

4. Malmberg, M.: Some Histologic Organic Changes After Cod Liver Oil Medication, Acta pædiat. **8**: 364-374, 1929.
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11. Prepared by the Whittier process.

occasions, but it was estimated that 3,500,000 U. S. P. units was retained during the period. The patient had diarrhea on the seventh day of administration; he died following a diagnostic cisternal puncture six weeks after completion of therapy. Postmortem examination showed deposits of calcium in the renal tubules, but none was found in other organs or vessels.

The author considered the toxic dose of this preparation to be 85,000 U. S. P. units per kilogram of body weight daily and felt that the drug was safe to use because of the high dosage required to produce the toxic effects. With the large dose used, abnormal calcification in the kidneys did occur from use of this electrically activated ergosterol product.

SUMMARY OF AUTHOR'S CASE

History.—A white married woman aged 29 was first admitted to the University Hospital in January 1940 complaining of attacks of diarrhea, with six to eight liquid stools per day, generalized malaise, occipital headache and a feeling of "tightness" between the eyes. With some attacks there was pain in the upper back and neck and a sensation of stiffness in the neck. These attacks had occurred at intervals of four to six weeks over the previous three years. Each attack lasted four to five days. There was some nausea at times but no vomiting. She had been considered to have a peptic ulcer by her local physician and in January 1938 had been placed on a bland diet with six feedings daily. Because of this restricted diet she took vitamin supplements consisting of "irradiated yeast tablets," vitamin E and vitamin C at least 100 mg. per day. The doses and the duration of this vitamin medication are unknown. The patient had other complaints for which no adequate explanation could be offered at the time. These consisted in "twitching in her legs" and shooting pains in the fingers and toes and on the right side of the body. Physical examination at that time revealed no abnormalities. The sigmoidoscope showed a normal bowel. The urine examination was normal except for a trace of albumin; feces were normal. The Kahn flocculation test for syphilis was negative. The basal metabolic rate was minus 1 per cent. The routine blood examination was negative. The patient was discharged after a period of five days' hospitalization without a diagnosis having been made. Because of the multiplicity of apparently unrelated complaints and normal physical findings and laboratory results, the possibility of a functional etiology was considered but the attending physician did not feel justified in explaining the illness on this basis, believing that some undetected organic disease may have existed. He thought that possibly an allergic process may have been the basis for her complaints, for she gave a history of urticaria from chocolate and wheat.

In January 1943, at the age of 32 years, she was again admitted to the medical service complaining of aching pains in the joints and in the extremities between the joints. Since her previous hospitalization she had not had diarrhea, but for one month in February 1942 she had vomited three to four times each day. During this period it was reported that the hemoglobin was reduced from 100 per cent to 60 per cent. She had continued to have severe headaches, nasal obstruction and postnasal drip. For two years there had been a persistent hacking cough productive of a small amount of greenish yellow sputum which had been blood tinged a year before and on several occasions during the week before admission. There had been mild dyspnea even at rest, and attacks of palpitation had been frequent during the preceding year. Three months prior to admission she rather rapidly became worse and was confined to bed. Swelling of the knees and ankles developed, and later there was swelling of both lower extremities below the knees. Nodules appeared along the extensor tendons of the fingers, on the pressure areas of the ulna, over the ischial tuberosities and the sacroiliac regions and along the tendons of the hamstrings. Contractures of each fourth and fifth finger and thickening of the palms developed. There had been aching pains in all extremities, with weakness and ease of fatigue. Anorexia was a prominent symptom; the patient had lost 15 to 20 pounds (7 to 9 Kg.) of weight during the previous four months. Considerable paresthesia of the fingers and toes had been present for three weeks. For two weeks there had been severe insomnia and disturbing dreams. For a few days there had been nocturia of one to four times and burning pain on urination.

For a year before admission the patient had been taking a concentrated preparation of vitamin D marketed under the name of "Vitamin D (Plasta-Seal)."[12] The manufacturers stated that each gelatin capsule contained 50,000 international units of vitamin D prepared from ergosterol by irradiation with ultraviolet light supposedly to the point of production of calciferol with "negligible amounts of other irradiation products." The patient had taken at least two capsules (100,000 international units of vitamin D) a day for one year prior to admission, and from about six months until three months prior to admission she took as many as ten capsules (500,000 international units of vitamin D) a day. She had also usually taken two ordinary vitamin D pearls per day. About a quart of milk was consumed daily, and 0.65 Gm. of calcium lactate was administered three times daily. (The monthly cost for vitamin medication totaled about $30.)

Physical Examination.—The patient appeared acutely ill and to have been in poor health for a long while. She was dyspneic at rest and was constantly moving about in bed. There was

Vitamin D Intoxication, with Metastatic Calcification

Case	Age	Sex	Preparation	Dose per Day	Duration	Season	Menstruum	Major Pathologic Changes
Putschar..... (1929)	5½ mo.	♂	"Vigantol"	6 drops (2.2 mg. I. E.)	96 days	Not stated	Not stated	Calcification in the tubular epithelium, basement membrane and interstitial tissue of the kidneys; none elsewhere
Thatcher..... (1931)	18 mo.	♂	Irradiated ergosterol emulsion	16 cc. (twice the "curative" dose)	5 mo.	Summer	Not stated	Calcification chiefly in the lumen of the collecting tubules of the kidneys; none elsewhere
Thatcher..... (1936)	11½ mo.	♂	Cod liver oil (200 I. U. per Gm.)	400 to 1,200 I. U.	4 mo.	Summer	Not stated	Calcification in the lumen and in the cells of the collecting tubules of the kidneys; none elsewhere
Ross and Williams* (1939)	8-14 mo.	♂	"Ostogen" (irradiated ergosterol, 60,000 I. U. per Gm.)	20,000 to 40,000 I. U.	"Several months"	Not stated	Not stated	Calcification in the kidneys, stomach, lungs and inner layer of the media of the arteries
Wolff† (1943)	4 mo.	♂	"Ertron"	300,000 I. U.	14 days	Summer	Milk	Calcium deposits in the renal tubules
Bauer and Freyberg (1946)	32 yrs.	♀	"Vitamin D Plasta seal"	100,000 to 500,000 I. U.	At least 1 yr.	Summer and winter	Water	Calcification in the kidneys, heart and arterial vascular system

* This is 1 of 4 cases described as a group, and the data are not definite.
† Calcification in this case was reported as an incidental finding and was not considered to be the immediate cause of death.

12. Dispensed by the U. S. Standard Products Company, Woodworth, Wis.

moderate pallor, and a few scattered areas of brownish discoloration of the skin were present. The teeth were in a good state of repair. There was moderate distention of the cervical veins. The left lung was clear. Bronchial breathing and numerous crackling inspiratory rales were heard over the middle third of the right chest. The heart size was normal. A diastolic gallop rhythm was present. One observer reported

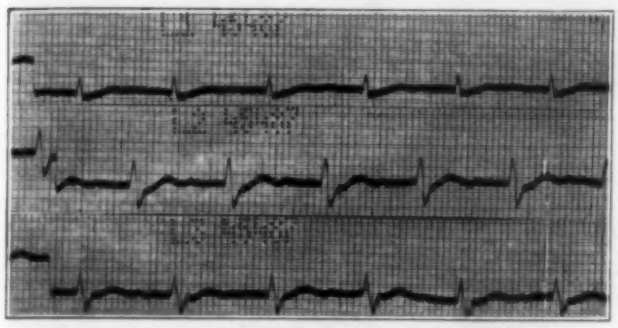

Fig. 1.—Tracing taken Jan. 30, 1943.

a rough diastolic murmur at the apex, but this was not detected on later examinations. The liver was just palpable and was not tender. There was mild epigastric tenderness. Large, firm nodules and conglomerate masses were present over each ischial tuberosity, and smaller masses occurred over the sacroiliac joints. There was pitting edema, grade 3, below the knees and tenderness on pressure throughout the lower part of the legs and over the dorsum of the feet. Motion of the joints was normal except in the fingers, where extension was incomplete. The palms of the hands were thick, rough and knotty, with the greatest thickness over the fourth and fifth metacarpal regions. There was a slight contracture of these fingers. The left wrist was slightly thickened, and there was increased heat and limitation of dorsiflexion.

Laboratory Results.—Voided urine on four occasions had a specific gravity ranging from 1.011 to 1.024. There was a trace of albumin only once. The sediment contained 2 to 4 erythrocytes per high power field on one occasion; there were 1 to 15 leukocytes per high power field, and the casts ranged up to 3 per low power field. On admission the hemoglobin was 54 per cent (Sahli). The white blood cell count was 10,600 per cubic millimeter, with 82 per cent polymorphonuclear leukocytes, 16 per cent lymphocytes and 2 per cent monocytes. The white blood cell count gradually rose, so that five days before death it was 17,800 per cubic millimeter. The eosinophil count varied from 0 to 6 per cent. The erythrocyte sedimentation rate was 0.75 mm. per minute on admission. The feces were normal. The total protein content of plasma was 5.8 mg. per hundred cubic centimeters, albumin 3.7 and globulin 2.1 mg. per hundred cubic centimeters. The sputum was studied on five occasions. There were no pneumococci types 1 through 33 on Neufeld reaction, and a culture for pneumococci and mouse inoculation were negative. No acid fast bacilli could be found in the sputum by the concentrate, culture or mouse inoculation methods. Pyogenic cultures showed Staphylococcus aureus and Streptococcus viridans. Fungus cultures were negative. A Fontana stain showed a few spirochetes and fusiform bacilli. The Kahn flocculation test for syphilis was negative. An electrocardiogram [13] (fig. 1) showed that the heart rate was 100 per minute, the PR interval 0.28 second, the QRS interval 0.10 second. The character of the curve suggested myocardial changes. Chest leads showed no evidence of intraventricular block other than the slightly increased QRS interval. Because of the lengthening in the QT interval and increase in the value of Bazett's index sometimes found in cases of hypocalcemia, this was computed to see if it might be shortened, thus giving evidence of hypercalcemia. This was not found to be true in this case. Roentgenograms of the chest on Jan. 30, 1943 showed mottled pulmonary consolidation in the lower right lung, the left lung being normal. The causation was considered as indeterminate, although the x-ray appearance was that of pneumonia. On February 5 the increased density at the right base was more definite and there was a new patchy density at the level of the first anterior interspace on the right. The left lung showed an increase in density similar to that on the right (fig. 2). Other laboratory studies were planned but could not be performed because of the unexpected death.

Hospital Course.—The patient was increasingly restless throughout the terminal illness. She sat propped up in bed partly because of dyspnea but more especially because of discomfort when lying supine. The annoying cough persisted. A small amount of mucoid sputum was raised with considerable difficulty. The patient was lethargic at times and had to be constantly encouraged to take food and fluids. She complained of aching epigastric pains at times, and emesis occurred once or twice a day. No blood was seen in the vomitus. Physical signs in the chest corresponded to the x-ray changes. A striking feature was the minimal febrile response despite the apparently extensive pulmonary involvement. During the first seven hospital days the temperature did not exceed 99 F. and the maximum temperature the next four days was 101 F. There was then an afebrile period lasting three days followed by a period of fever not exceeding 100 F. during the terminal three days. The pulse fluctuated widely but averaged between 95 and 100 beats per minute. Respirations were between 25 and 30 per minute. On the thirteenth hospital day the patient suddenly complained of pain in the right foot and calf of the right leg, which became definitely cold, and the toes were cyanotic. This condition spread to involve the entire leg from a point 5 cm. below the knee. The right posterior tibial and dorsalis pedis pulses were absent. These changes were considered to represent signs of arterial occlusion. An effort to reduce the metabolism of the ischemic tissue with ice had to be discontinued because of a severe fall in the general body temperature. During the next three days there was slight improvement in the condition of the right leg. At this time, however, there was again a sudden increase in the pain, and it was felt advisable to effect a lumbar sympathetic procaine anesthesia. This was done, 25 cc. of 1.5 per cent procaine without epinephrine being used. No immediate objective effects were noted, but the patient said that both legs felt numb below the knees. She seemed to tolerate the procedure very well and was observed unchanged with no complaints thirty minutes after injection. Ten minutes later she was found dead in bed.

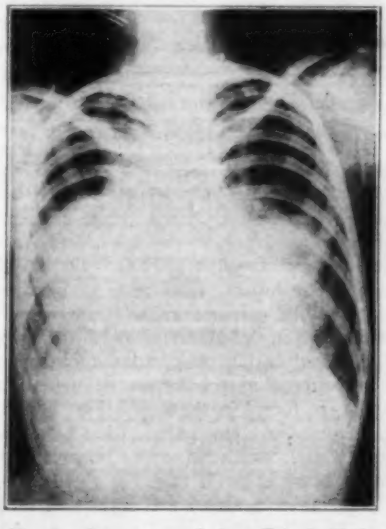

Fig. 2.—Appearance of chest Feb. 5, 1943.

Necropsy Findings.[14]—The main gross pathologic change was the presence of white, chalky looking material in the myocardium, kidneys and arterial vascular system. These white deposits were sometimes continuous, so that an entire artery appeared white when viewed from the intimal side, and on cross section the inner portion of the media consisted of a white ring. The myocardium cut with increased resistance and throughout was found to be speckled with grayish white dots. The endocardium over the apexes of the papillary muscles and over the valve rings and leaflets had a white appearance. Many white flattened plaques were noted beneath the endocardium of the left auricle and at the base of the aorta. The coronary arteries were white as viewed from the intimal surface but were patent and thin walled. The aorta and the iliac, splenic

13. Dr. Franklin Johnston interpreted the electrocardiograms.

14. Dr. Carl V. Weller interpreted the microscopic sections.

and mesenteric arteries also showed this pure white color. The kidneys were pale and of normal size. After sectioning, the surface presented a fine granular appearance; distinction between cortex and medulla was not sharp. There were grayish white radiating lines passing out into the cortical area. Fibrous appearing masses of chalky white material were found in and beneath the dura; these could be easily removed from the bony ridges at the base of the skull after removal of the dura. Grayish white opaque areas were also scattered over the falx cerebri and tentorium cerebelli. Both lungs were irregularly firm throughout and moderately edematous. There was no definite consolidation, nor was any portion friable, but the stroma of the lung seemed to be increased. The bronchi were patent; the bronchial mucosa appeared normal; there was no purulent exudate. A small infarct was found at the base of the right lung. There were multiple shallow ulcerations on the lesser curvature of the stomach just proximal to the pylorus. In the duodenum there was an old ulcer measuring 2 cm. in diameter which had perforated posteriorly into the head of the pancreas. Adjacent to this there were three small acute ulcerations. The only peripheral joints examined were the right knee and ankle. On the surface of the synovium and articular cartilage pearly white plaques were seen.

The microscopic study showed the diffuse white material distributed throughout the arterial vascular tree and in various

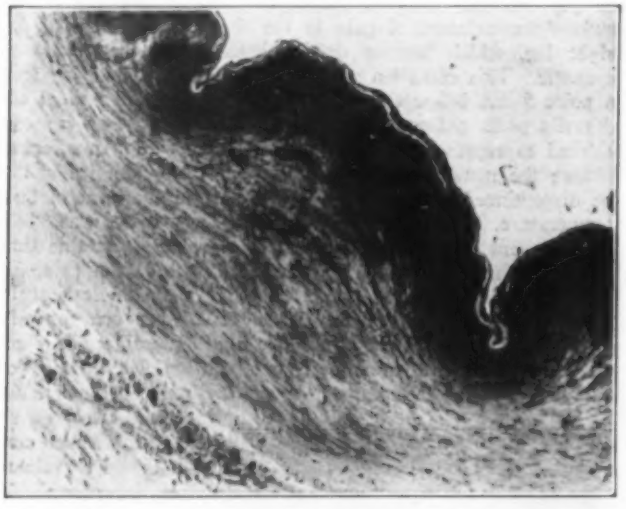

Fig. 3.—Section of artery showing extensive calcification involving inner portion of media.

other sites to be deposits of calcium salts (fig. 3). There were numerous myocardial infarcts in various stages and patchy areas of degenerative fatty infiltration. Dense calcification formed almost a continuous layer in the left auricle and extended to the margin of the mitral valve (fig. 4). The larger coronary arteries showed slight intimal thickening and diffuse impregnation of the media with calcium salts. The smaller coronary branches within the myocardium showed advanced calcification, which had resulted in the obliteration of many of them. Patchy lipoidosis occurred in the intima of the aorta, and areas of calcification were found in the media just beneath the intima. The kidneys showed extreme calcification involving chiefly the blood vessel walls, which in areas appeared to secondarily involve tubules and glomeruli (fig. 5). The larger renal arteries showed great thickening of the intima, but the intense calcification was in the media. Well defined arteriosclerotic nephropathy was present. The brain was congested, and hemorrhage by diapedesis had occurred in the perivascular spaces. Neither the meningeal nor the cerebral vessels showed calcification, but there was much lime salt in the dura mater and some in the pineal body. Calcification in the lungs was chiefly confined to the small vessels of the bronchi, bronchioles and alveolar walls of those portions where there was chronic fibrous pneumonitis. The cartilage plates of the medium sized bronchi showed heavy calcification with metamorphosis to bone. In some of the pulmonary alveoli there were groups of phagocytes containing lipoid material. There was heavy calcification of the perichondrium of the larynx, trachea and large bronchi, in the smooth muscle of the bronchial walls and in the thyroid and thymic arteries. The splenic and mesenteric vessels con-

Fig. 4.—Section through mitral valve showing calcification in valve leaf above and valve ring and myocardium below.

Fig. 5.—Calcification in and about renal tubules.

tained considerable calcium. The base of the chronic duodenal ulcer was formed of adipose and pancreatic tissues. There was chronic interstitial pancreatitis, and some of the small peri-

pancreatic arteries were almost obliterated by intimal proliferation inside the zone of calcification. The specimen from the region about the left ischial tuberosity showed adipose tissue and fascia, with heavy calcification of vessel walls and chronic productive inflammation. The tissue from the right knee and ankle showed some areas of calcification of the joint capsule, with a thickened synovial membrane in which there was some osteoid tissue. In other areas the synovial membrane showed only a mild chronic inflammation with slight development of villi. A section of rib and sternum showed a cellular marrow. The bony trabeculae were widened by the deposition of a broad layer of new formed bone on them.

COMPARISON OF PREVIOUSLY REPORTED CASES WITH THE PRESENT CASE

All previously reported cases of vitamin D intoxication with metastatic calcification (with the possible exception of the case reported by Wells and Holley [5]) were boy infants from 4 to 18 months old. The vitamin D preparation producing the toxic effects included simple fortified cod liver oil, ultraviolet irradiated ergosterol and electrically activated vaporized ergosterol. The daily dose ranged from 400 to 30,000 international units. Since body weight was not given in most cases, the dosage in units per kilogram of body weight cannot be computed. The shortest length of time over which the drug had been given before demonstrable calcification was produced was fourteen days. In only 3 instances was the time of year during which the drug had been given mentioned; in these 3 cases it was summer, when more abundant ultraviolet light would be available. Since all patients were infants, it is to be assumed that they received abundant milk in their diets. In only 1 case was it stated that the vitamin preparation was given in milk. This is important, since Lewis [15] has shown that by using milk as a menstruum for vitamin D the antirachitic value of the vitamin was much greater than that of a similar dose given in corn oil or propylene glycol. Metastatic calcification, the chief pathologic finding in all cases, was limited to the kidneys in 4 cases; in the fifth case it was also found in the stomach, lungs, and in the inner layer of the media of arteries quite generally distributed.

With the possible exception of one other,[5] our patient is the only adult in whom vitamin D intoxication led to metastatic calcification. Also in no other reported case did the condition occur in a female. The amount of irradiated ergosterol taken by our patient was from 100,000 to 500,000 international units per day and is more than was taken in most of the previously reported cases. However, calculated as units per kilogram of body weight (2,200 to 11,000 international units per kilogram daily) she received a relatively smaller dose and considerably below the value of 20,000 international units per kilogram of body weight per day, usually considered as the minimum toxic dose for the human being.[16] In our case vitamin D had been taken for over a year, a longer time than in any of the reported cases. Two other factors which would tend to increase the toxicity of the vitamin D in our patient were the high intake of calcium and a tendency toward mobilization of calcium from the bones as a result of confinement to bed during the last three months of her life. Metastatic calcification was as extensive as in any case previously described and was quite characteristic of that seen in experimental vitamin D intoxication.

15. Lewis, J. M.: Further Observations on the Comparative Antirachitic Value of Crystalin Vitamin D Administered in Milk, Corn Oil and Propylene Glycol, J. Pediat. **8**: 308-314, 1936.
16. Reed, C. J.; Struck, H. C., and Steck, I. E.: Vitamin D: Chemistry, Physiology, Pharmacology, Pathology, Experimental and Clinical Investigation, Chicago, University of Chicago Press, 1939.

PATHOLOGY OF VITAMIN D INTOXICATION

Our case is a remarkable example of the advanced stages of vitamin D intoxication. Opinion is divided as to the pathologic changes occurring in the earlier stages of intoxication. Steck, Deutsch, Reed and Struck [17] feel definitely that cellular damage occurs first and that calcium is then deposited in these injured areas. Ham [18] considers that the pathologic calcification is not preceded by cellular damage, since he was unable to demonstrate changes in cells twenty-four hours after administration of the drug to rats, yet at forty-eight hours massive pathologic calcification had occurred. The pathologic calcification involves chiefly the kidneys, lungs, stomach, arterial vascular system and myocardium. The calcium can usually be seen grossly as a gray-white deposit in the media of arteries and irregularly distributed through the involved organs. On microscopic examination the calcium in the kidneys is reported to be found chiefly in the lumen of the collecting tubules or in the tubular cells. In our case the renal calcification seemed to be primarily in arterioles, the tubular and glomerular involvement being secondary. In the stomach it frequently occurs in the acid-secreting cells, supposedly because of the fact that acid secretion renders these cells more basic and thereby favors calcium salt deposition. The same mechanism is proposed to explain the occurrence of calcification in the lungs, where elimination of carbon dioxide leaves the tissues more basic. Calcification in the myocardium is often associated with necrosis and infiltration with mononuclear and polymorphonuclear leukocytes. The arterial calcification is well described by Vanderveer [19] in reports of experiments on rabbits. It is limited to the media and usually occurs in the inner third of this layer; the intima appears to be entirely spared. Harrison [20] has reported that he was able to produce combined "cholesterol sclerosis" (in the intima) with vitamin D sclerosis (media) in rabbits. No matter which lesion was produced first, the subsequent process involved only the part of the vessel uninvolved by the other process. Harrison considered this to indicate that the lesion first produced immobilized that section of the artery and prevented subsequent sclerosis in that area by the other method.

SYMPTOMS OF VITAMIN D INTOXICATION

The most frequent symptoms of toxicity from vitamin D are anorexia, nausea and vomiting, diarrhea (sometimes with bloody stools), polyuria, muscular weakness, lassitude and headache. Some patients show profound depression. Reed, Struck and Steck [16] describe a sensation of tightness and hyperesthesia across the occiput when lying supine. Our patient presented many of these symptoms; whether all can be attributed to the excessive vitamin D must remain conjectural, but they are worthy of consideration. During the first hospitalization she had complained of periods of nausea, diarrhea, occipital headache, pain in the upper part of the back and the neck, and stiffness of the neck. At this time she reported taking some "irradiated yeast tablets and liver capsules." She may have been receiving toxic doses of vitamin D at that time. During the last

17. Steck, J. E.; Deutsch, H.; Reed, C. I., and Struck, H. C.: Further Studies on Intoxication with Vitamin D, Ann. Int. Med. **10**: 951-964, 1937.
18. Ham, A. W.: Mechanism of Calcification in the Heart and Aorta in Hypervitaminosis D, Arch. Path. **14**: 613-626 (Nov.) 1932.
19. Vanderveer, H. L.: Hypervitaminosis D and Arteriosclerosis, Arch. Path. **12**: 941-955 (Dec.) 1931.
20. Harrison, C. V.: Experimental Arterial Disease Produced by Cholesterol and Vitamin D, J. Path. & Bact. **36**: 447-453, 1933.

period in the hospital she complained of anorexia, weakness, fatigue, aching pains in the arms and legs and a loss of 15 to 20 pounds in the previous four months. There was burning on urination and nocturia. She showed psychic changes, was restless and depressed, and later was at times irrational. These psychic changes were poorly understood at the time but they probably represented the toxic effects of vitamin D.[16] The occurrence of pigmentation in the skin of 2 persons who had taken vitamin D over long periods was reported by Reed, Struck and Steck.[16] Small areas of brownish pigmentation were found on the skin of our patient. The absence of significant abnormal urinary constituents is noteworthy in view of the changes in the kidneys encountered at the postmortem examination. The fact that the primary renal lesion was one of vascular calcification, with the tubules and glomeruli being involved only secondarily, may in part explain the lack of abnormal urinary findings.

ABNORMAL CALCIUM METABOLISM IN VITAMIN D INTOXICATION

In order to understand how such extensive metastatic calcification occurs under the influence of large doses of vitamin D it is necessary to review briefly the present knowledge of calcium metabolism, which is admittedly incomplete. There is more calcium in the serum at all times than can be accounted for by the laws of simple solution. Barr[21] states that only about 25 per cent of the serum calcium can be accounted for on this basis. At least two other factors are considered to be active to maintain the remainder of calcium in the serum. The more important of these is the hormone of the parathyroid gland, which holds some 40 to 50 per cent of the normal serum calcium in solution. In some way the action of vitamin D is related to this fraction of the total serum calcium, but the exact relationship of the vitamin and parathyroid hormone is not settled. Another factor is the combining effect of serum proteins, which hold about 30 to 40 per cent of the normal serum calcium in solution. Abnormal tissue calcification can occur with total blood calcium values that are not elevated[22] and, conversely, the total serum calcium may remain quite high for a long time without producing pathologic calcification. These facts indicate the importance of qualitative factors emphasized by the studies of Ham and Portuondo.[22] These workers found that following the administration of massive doses of irradiated ergosterol to rats and rabbits pathologic calcification did not appear while the serum calcium was rising but it was considerable while the serum concentration was falling. They explained this observation as follows: The rise in serum calcium was due to an increase in the fraction controlled by the parathyroid hormone, the calcium coming from the intestine, bones and other tissues. As the serum calcium fell there was a rapid release into the serum of calcium from this parathyroid controlled fraction, which would necessitate holding a large amount of calcium in solution in the serum until it could be deposited or excreted. Since the capacity for solution of calcium in the serum is sharply limited, precipitation of calcium in the tissues results. Thus it appears that a rapidly fluctuating level of serum calcium is more likely to produce pathologic calcification than a persistently elevated one.

21. Barr, D. P.: Pathological Calcification, Physiol. Rev. **12**: 593-624, 1932.

22. Ham, A. W., and Portuondo, B. C.: Relationship of Serum Calcium to Pathological Calcifications of Hypervitaminosis D, Arch. Path. **16**: 1-14 (July) 1933.

In the light of this explanation it should be recalled that our patient had taken large daily doses of irradiated ergosterol for at least one year before her death, and from six to three months prior to her last hospital admission she had taken five times her usual daily dose of 100,000 international units. The usual smaller daily dose was resumed three months prior to admission; at about this time her condition became worse. When she entered the hospital vitamin D was completely discontinued and her clinical course was progressively worsened. We do not have serum calcium determinations to substantiate this sequence of events, but it is possible that this program of vitamin D intake in our patient resulted in a condition analogous to that observed by Ham and Portuondo in experimental animals. A recent attempt at deposition of calcium in bones is suggested by the appearance of the bone trabeculae, which were widened by a broad layer of new formed bone. If this could not proceed with sufficient rapidity or the excretion of calcium was insufficient, pathologic tissue calcification would result.

Even though blood calcium determinations were not made and hypercalcemia observed, because the clinical and pathologic abnormalities are so characteristic and because of the history of prolonged high vitamin D intake and the inadequacy of other possibilities to explain the pathologic changes, we are confident in ascribing the illness and death to vitamin D intoxication. Other factors may have played a part in the pathologic calcification in this case. Ham[18] quotes Wells as stating that calcium can be precipitated from serum of high carbon dioxide content by rendering the serum more alkaline. Some degree of alkalosis may have occurred in our patient, since she vomited frequently and had constant hyperpnea. She also had considerable gastrointestinal difficulty, and postmortem examination showed a penetrating peptic ulcer and several acute gastric and duodenal ulcers. Reed, Struck and Steck[16] mention that patients who have gastrointestinal complaints, especially diarrhea and constipation, are more susceptible to the toxic effects of vitamin D. It is possible that some of the abnormal calcification occurred within the last few days of the patient's life. The poor organization of the calcium deposits in the arteries and between the dura mater and the skull suggests recent deposition. That this type of calcification can occur in as short a period as forty-eight hours after administration of irradiated ergosterol to experimental animals has been shown by Ham.[18]

COMMENT

Mild symptoms of vitamin D intoxication, such as gastrointestinal and genitourinaray complaints, are not uncommon during the use of large doses of this drug. It is important to detect these earlier symptoms and reduce the dose or withdraw the drug to avoid the potential danger of more serious toxic effects. The most severe toxic effect is the occurrence of metastatic calcification, which may lead to death. This is rare in the human being and especially in the adult, but the fact that it does occur should suffice to make one cautious. The fact that reported deaths from excessive amounts of vitamin D have usually been in infants may suggest greater susceptibility of the young or simply that the doses given were greater per unit of body weight. However, until recently large doses of vitamin D have been given only to infants and children, and in most adults the symptoms of vitamin D toxicity are appreciated and the drugs discontinued, whereas in infants its administration may be unwittingly continued.

In recent years large doses of vitamin D preparations have been prescribed for the treatment of a wide variety of diseases, including arthritis, pollinosis, tetany, psoriasis, acne and trichonosis. A discussion of the efficacy of this form of therapy in these widely divergent clinical conditions is beyond the scope of this paper, but it might be well to state that in most cases the administration has been largely on an empirical basis and the results reported vary considerably, many being contradictory. It is regrettable that the use of these potentially toxic preparations has been advocated in the lay press and the medications have been sold to the public without need for prescription. Our case is an example of the injudicious self medication with one of these preparations and indicates their potential danger. There is great variation in species susceptibility and individual susceptibility to the toxic action of vitamin D. It is usually stated that the threshold of toxicity in the human being is 20,000 international units per kilogram of body weight daily, but Reed and his associates [16] report toxic effects in one adult with as little as 1,000 international units per kilogram of body weight daily. The severe toxicity in our patient was produced by from 2,200 to 11,000 international units per kilogram daily. The susceptibility of an individual will vary at different times, and Reed, Struck and Steck [16] found that toxicity was more likely to occur in patients with gastrointestinal dysfunction, especially constipation and diarrhea. They reproduced toxicity at will by creating a gastrointestinal disturbance in a person taking large but previously subtoxic doses of vitamin D. According to these investigators the factors which influence the toxicity of vitamin D are the dose per unit of body weight, the route and duration of administration, the composition of the diet in regard to the mineral and organic contents, the state of the alimentary tract, species susceptibility, age, preexisting pathologic conditions, the vehicle in which the vitamin is administered, the state of the endocrine system, the purity of the vitamin preparation, the source of the vitamin and other factors not yet recognized.

The toxic properties depend in part on the method of production of the vitamin preparation. This is illustrated by the frequent toxic effects of the earlier ultraviolet irradiated ergosterol, which contained large amounts of toxisterol. The electrically activated ergosterol [23] produced by the Whittier method appears to have properties somewhat different from vitamin D produced by ultraviolet irradiation of ergosterol. It appears to be less toxic, but until more is known of this preparation it too should not be used indiscriminately, for calcium deposits were found in the kidneys of an infant by Wolf [7] after the administration of 300,000 international units daily of this drug for two weeks.

SUMMARY

One is not justified in drawing too many conclusions from the limited data available on this subject, but from a review of the cases presented the following conclusions seem permissible:

Concentrated vitamin D preparations, especially when administered in large doses, should be considered as potentially toxic drugs. Their administration should be carefully supervised and the recipient should be kept under close observation in order to detect symptoms of toxicity. When given in excess of tolerance, characteristic symptoms result which should be recognized in order to forestall more serious consequences. In the human being death may occur, even in the adult, as a result of vitamin D intoxication causing calcification of organs and arteries. There are at least 5 such instances (including our case) reported. The intoxicating dose depends on many factors and varies greatly in different persons and at different times in the same person.

In experimental animals pathologic calcification and death may occur without hypercalcemia. Pathologic calcification seems to depend more on fluctuations of serum calcium than hypercalcemia per se and may occur only during the decline of hypercalcemia.

23. Ertron, produced by Nutrition Research Laboratories, Inc., Chicago.

THE PSYCHOSOMATIC ASPECTS OF STERILITY

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Although pregnancy is a much investigated process and although the science of obstetrics has advanced greatly in the past fifty years, we still do not know the answers to some of the fundamental questions regarding just what happens to a woman when she becomes pregnant. The theory that the emotional state of a woman might influence conception probably would seem unimportant to gynecologists were it not for its application to the widespread problem of sterility.

Physicians, as well as nonmedical groups, are becoming increasingly aware of the importance of psychosomatic investigation. Psychosomatic medicine is that discipline which recognizes the fact that psychic and somatic phenomena are inseparably interwoven. It is now a well accepted fact that we can no longer adhere to the dichomatous concept of man. We no longer can separate an individual into psyche and soma. What affects one affects the other and vice versa. Emotional conflicts can result in somatic dysfunction, and psychologic therapy is often able to affect improvement in such dysfunctions. It has been demonstrated over and over again that an idea can be converted into a symptom. One has only to think of the phenomenon of "watering of the mouth" when a person thinks of eating a tart substance. The stimulation of the salivary glands arises in the psychic field, and the increased salivation is due to an idea rather than to any mechanical or chemical stimulus of the salivary organs. One has only to think of the increased rate of the heart when a person is under emotional stress. One has only to think of the engorgement of the face referred to as "blushing" in certain psychiatric situations. That emotional conflicts can result in somatic dysfunction in the generative organs as well as in other organs seems inevitable. If, as well as others, the gastrointestinal and the cardiovascular systems can be affected by emotional states, why is it not reasonable to suppose that the generative organs can be affected by such states?

Although no organic basis for their disability can be found, many women do not conceive. With some changes in the life situation of some of these women (for example, after adoption of a child) but without demonstrable changes in their structure or their physiology, they become fertile. This has become such common knowledge that married couples about to adopt a child often hear predictions to the effect that they will now have a child of their own. This frequently comes to pass. Unfortunately we do not possess accu-

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Dr. J. Murray Scott of Ayerst, McKenna and Harrison, Ltd., of New York, rendered valuable assistance in obtaining data on the neurophysiology of ovulation.

rate statistics on the frequency of such events; but since almost every one knows of one or several such instances, they must occur rather frequently. Here is another case in which common experience and observation seem to agree with the psychosomatic point of view that psychologic factors may play a significant part in the ability of a woman to conceive.[1]

The first careful psychologic study of a childless married couple who had a child of their own shortly after they decided to adopt one was made by Orr.[2] He studied a couple who remained childless for several years after they were married. Eventually they decided to adopt a child. Both the husband and the wife had been psychoanalyzed. It was found that the husband had a need to remain emotionally dependent on his wife (as a parent figure) and he had encouraged her to continue working and she keenly resented this. In the wife's analysis it was brought out that she never had been permitted by her parents to be feminine, and this furnished some very rich conflict material. Her parents had wanted a son and, instead of treating her as a girl, they had treated her as a boy, dressed her in tailored clothes, encouraged her to develop and retain a boyish figure and urged her to engage in athletics and also to play golf with her father. Emphasis was also placed on the importance of her being independent and self supporting, and she was taught to associate these traits with masculinity. When, after marriage, she was compelled to continue working and was encouraged to do so by her husband, she found herself in a situation similar to that in which she had been before marriage, with her husband now assuming the role formerly played by her father (father substitute). Her conflict revolved around the fact that if she became pregnant she would have to stop working outside the home and abandon the masculine role. This was in direct conflict with her early training and bringing up, which had taught her to retain the masculine role.

The decision of this young couple to adopt a baby on a definite date made it necessary for the wife to give up her job. Having done this, her hostility toward her husband decreased and her dissatisfaction with herself in the masculine role was modified. Her formerly deprecated femininity now became an important factor in this young woman's personality, and it is interesting to note that she became pregnant in a few weeks after giving up her job and assuming the care of the adopted child.

This is but one case of apparent sterility in which the psychologic material has been studied from the psychoanalytic point of view. However, thousands of similar cases exist, and many of them have been dealt with from various psychiatric points of view. It appears quite clear that when a previously childless couple have a child of their own after making the decision to adopt one the probability of psychologic factors being present as a cause of the previous infertility is more apparent than in those cases of childlessness in which no event occurs to demonstrate possible factors.

Aside from Orr's contribution, the literature consists mainly in discussions on the possibility that sterility may be psychogenic. Dunbar[3] states ". . . that psychic influence, associated with a vivid but unsatisfied desire for a child, may stimulate the ovaries to pathological growth. It is possible that this may result in premature maturation of the follicles and discharge of ova which are not yet ready for fertilization, and the consequent sterility. That the peculiar cases of first conception after fifteen or twenty years of married life may be explained by the fact that as a woman is gradually reconciled to her sterility this injurious influence on the follicular apparatus disappears" (p. 341). In other words, although women may ovulate more or less regularly, interference with the neuroendocrine control of ovulation may result in the production of an ovum that is not ready for fertilization, or it may result in some other dysfunction which interferes with the process.

In view of the variety of mechanical and chemical (chiefly endocrinologic) processes involved in conception, it is a priori almost impossible that psychic functions should not play a part. Furthermore, every one is aware of the influence of psychic factors on the endocrines, and this gives additional justification for the belief that psychically influenced hormonal processes may play a part in conception. Selltim believes that we have to reckon with a possibility of postponement of ovulation (or the opposite), since with all emotions there is a decided change in abdominal circulation. This is synonymous with the possibility of favoring or hindering conception (pp. 341-342).

Menninger[4] states that "the premature maturation of the follicles resulting from hyperactivity of the ovaries may in some cases be cured by psychotherapy, in others by a gradual reconciliation of the woman to her sterility, this reconciliation thus serving to decrease the pathological (emotional) stimulation of the ovary and hence allowing it to discharge normal ova and to terminate the sterility, as when a child is born after a couple has adopted one" (p. 522). Knight[5] says "it not infrequently happens that a childless wife does become pregnant sometimes after adopting a child, although the adoption did not take place until the couple were thoroughly convinced that conception was impossible. One is led to theorize that unconscious opposition to childbearing might have been responsible for the functional sterility and that this unconscious opposition is somehow overcome by the experience of adopting and taking care of a child. How the unconscious opposition to childbearing might have operated to thwart the constant attempts to achieve conception is a moot question. One possible hypothesis is that the unconscious of the woman . . . may affect the physiology of ovulation or implantation in such a way as to prevent conception. Another hypothesis is that there is an unconscious awareness in the woman of the time and fact of ovulation and that she manages to avoid coitus at the critical period" (p. 66).

What is the healthy attitude toward becoming pregnant? As far as woman is concerned, pregnancy is the highest type of creativeness; it represents the chief goal of feminine psychosexual maturity. One of the first things that a woman thinks about after she is married is the possibility or probability of her becoming pregnant. Regardless of what their eventual wishes or plans may be, the threat of a possible immediate pregnancy often is a major factor in determining marital adjustment. Previous sexual information and experience, the nature of the sexual relations with the husband, the

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2. Orr, D. W.: Pregnancy Following the Decision to Adopt, Psychosom. Med. **3**: 441-446 (Oct.) 1941.
3. Dunbar, H. F.: Emotions and Bodily Changes, ed. 2, New York, Columbia University Press, 1938.
4. Menninger, K. A.: Somatic Correlations with the Unconscious Repudiation of Femininity in Women, J. Nerv. & Ment. Dis. **89**: 514-527 (April) 1939.
5. Knight, R. P.: Some Problems Involved in Selecting and Rearing Adopted Children, Bull. Menninger Clin. **5**: 65-74 (May) 1941.

religious mores involved in connubial relationships and a host of other factors necessarily modify the woman's attitude. If women fear becoming pregnant, the fear is usually focused on whether or not the pregnancy may come too soon after marriage or too soon after the last child, whether they are able to afford a pregnancy, whether one's social pleasures and freedom will be interfered with, whether or not the husband will approve of a pregnancy at a particular time, or on any one of a large number of other implications.

Just as there are many rationalizations and neurotic reasons for not becoming pregnant, there are many motivations for becoming pregnant. A woman may consider pregnancy a useful tool with which she can accomplish certain objectives. She may feel that pregnancy would provide an escape from intolerable family or social situations; it might bind her husband to her or hold him in the face of other attractions; or the woman may delude herself into thinking that if she becomes pregnant her husband will love her more. A woman may use pregnancy for ulterior motives, such as gaining or insuring support or inheritance. These are some of the conscious reasons why a woman might want to become pregnant. There is a growing opinion among psychiatrists that there may be many unconscious as well as conscious reasons why a woman may or may not want to become pregnant.[6] We all know what powerful influences unconscious wishes or fears can exert. On the conscious level we may think we know the reason why we do certain things, but the real motivation may be at the unconscious level and may be something altogether different from anything that we are aware of.

I think that we are all agreed that psychologic factors to a great degree enter into the question of the nausea and vomiting of pregnancy. Although in many cases the vomiting is unquestionably toxic in origin, approximately 50 per cent of the obstetricians questioned by Menninger [6] regarded nausea and vomiting as a psychologically motivated and produced symptom in the great majority of instances. Many of the physicians cited produced evidence to support their opinion. Many called attention to the type of person in whom vomiting most often occurred—"the well to do, the intellectual, the college girl." If mental conflict admittedly can cause the nausea and vomiting of pregnancy, it is conceivable to me that mental conflict also can interfere with other physiologic functions having to do with reproduction, such as ovulation, and produce sterility.

Assuming then that emotional conflict can result in disturbances of the functions of the sympathetic nervous system sufficient to bring about somatic changes, let us go on to what is actually known and what has been proved regarding the neurophysiology of ovulation and the neural pathways through which this function is mediated. Little is actually known in regard to the neurophysiology of ovulation in women, but certain fundamental principles are understood about the physiology of ovulation in animals.[7] Bellerby showed that ovulation does not occur spontaneously in the rabbit, but it may be induced in this animal by injections of an acid extract of the anterior lobe of the pituitary gland. Ovulation in the rabbit normally occurs ten to twelve hours after copulation. Hypophysectomy in this animal one hour after copulation prevents ovulation. Hypophysectomy performed later than one hour after copulation does not inhibit ovulation. These observations imply that rupture of the follicle and discharge of the ovum under ordinary circumstances are the result of a hormonal influence of some sort exerted by the pituitary. Apparently liberation of the hormone responsible for ovulation occurs within one hour after copulation. Smith, however, does not believe that any specific "ovulation hormone" exists but that ovulation is the result of a balance struck between the follicle stimulating and the luteinizing hormone. Afferent impulses from the genital tract are apparently responsible in part for the liberation during coitus of the pituitary principle causing ovulation, but they are not essential, for Fee and Parks have shown that ovulation occurs after the vulva and vagina have been anesthetized. Sexual excitement resulting in an orgasm is capable alone (i. e. without coitus) of causing ovulation in the rabbit. Now, sexual excitement is an acute emotional situation. It is an emotional situation in the same sense that rage and fear are emotional situations. Of course we are not naive enough to suppose that a rabbit is capable of the same emotional nuances regarding sex that a human being is capable of. However, we still are left with the fact that, in the rabbit at least, an emotional reaction can cause ovulation. Man being a relatively more complex animal, to me the conclusion is inescapable that ovulation can be adversely or favorably affected by an acute or chronic emotional state. Anxiety is chronic fear, and the same process acting over the same neural pathways most certainly must have some affect on ovarian function. In the rabbit ovulation may be induced by electrical stimulation of the cerebrum or the lumbosacral cord or by the intravenous injection of the convulsive drug picrotoxin. This shows that the influence on the pituitary gland is of central origin. It has been shown also that ovulation can be induced by stimulation of the cervical sympathetic, the hypothalamus, the hypothalamohypophysial tract of nerve fibers or of the pituitary itself.

It is very difficult to abolish the ovulation response. This is probably due to the fact that impulses reach the pituitary from many sources. Brooks sectioned the sacral spinal cord, both sympathetic chains and the uterus together with the proximal half of the vagina and still was unable to prevent ovulation after coitus. Ablation of the neocortex and of the olfactory lobes did not prevent ovulation. However, after section of the pituitary stalk ovulation no longer occurs. Therefore, as far as the rabbit is concerned, the evidence is conclusive that the pituitary gland is a necessary dynamic factor in the process of ovulation. Through the hypothalamohypophysial tract the pituitary is in direct connection with the hypothalamus and the thalamus. The thalamus has been referred to as the cerebral center for emotional reactions. Cats and other experimental animals who have been deprived of their higher centers down as far as the thalamus still are capable of such reactions as "sham rage." The evidence is good also in human beings that the thalamus has a lot to do with the emotional life. Thus we have established a chain of neural connections between the cerebral cortex, the thalamus, the hypothalamus and the pituitary. If we think of our intellectual functions as being functions of the cerebral cortex, of our emotional life as being a function of the thalamus, it does not require any stretch of the imagination to conceive of psychologic states such as anxiety and fear having a direct effect on pituitary function, i. e. ovulation.

6. Menninger, William: The Emotional Factors in Pregnancy, Bull. Menninger Clin. 7: 15-24 (Jan.) 1943.
7. Best, C. H., and Taylor, N. B.: Physiological Basis of Medical Practice, Baltimore, William Wood & Co., 1939.

Benedek and Rubenstein [8] have described interesting correlations between psychosexual responses and the level of ovarian function. They made a combined study by endocrine and psychoanalytic methods of 15 women of childbearing age during 152 menstrual cycles. While their studies appear to show that the psychic apparatus reacts strongly to incipient estrogen production and there is a definite interdependence between the amount of estrogen excreted, the time of excretion and the psychologic experience of the individual, they do not show any reverse relationship, i. e. the effect of food and other psychologic experiences on the amount of estrogen secreted. In other words, as far as I know, no experimental work has been done on the affect of certain emotional states on the amount of estrogen secreted. However, some years ago I made an observation on a patient which strongly supports the thesis that psychologic situations exert a strong affect on estrogenic function. This was the case of a woman who was living in a very unsatisfactory sexual relationship with her husband. The reasons for the sexual maladjustment were entirely psychic: there was no anatomic reason why this woman could not live a normal sex life. The woman's husband was engaged in work which took him away from the city at irregular intervals. Furthermore, the duration of his stay away from the city was extremely irregular. No matter when the husband returned to the home city and no matter how long he had been absent from the city, the woman would begin to menstruate on the day of his arrival! This observation was confirmed by one of my medical colleagues in St. Paul. Dr. Karl Menninger has told me that he has seen similar cases. This is indubitable evidence that psychologic situations, especially those colored by anxiety, can affect menstruation. By the same token it must be that they can affect ovulation and thereby have a pronounced affect on the fertility or the sterility of women.

I was once asked Why are not all women sterile who have sexual conflicts? Many cases were cited to me in which the wife had abhorred sexual intercourse, had detested her husband, had lived in constant fear of pregnancy and yet became pregnant almost annually. To me the answer lies in the fact that anxiety does not affect the same physiologic system in every individual. In one person anxiety will produce a cardiac neurosis, in another "nervous indigestion," in another headaches, in another tremors, in another frequent urination and in some others ovarian dysfunction.

Can there be a common meeting ground between "psychophysiology" and "neurophysiology." Grinker [9] concluded that "repression and inhibition, which are basic principles in psychoanalysis and neurology respectively, are dynamically identical." Both repression and inhibition indicate a negative factor in that a certain level of activity is abandoned and a positive factor which results from or is permitted by the shift of activity from one portion of the nervous system to another. "In the evolutionary (phylogenetic) process and in biological learning (ontogenetic) the shift is upward. In the devolutionary process of disease either functional or morphological, the shift is downward and is termed regressive." Therefore when we are psychologically repressed we are neurologically inhibited. Psychologic repression can be and probably always is accompanied by neurologic inhibition. Why in some women could it not be inhibition of the pituitary gland function? If functional derangement in pituitary gland activity can be brought about by disturbances in the psychologic activities of the individual, the evidence is good that psychologic states can affect ovulation. This, in my opinion, forms the basis for the psychosomatic element in some cases of sterility.

How can cases of "functional" sterility be detected? It goes without saying that every sterile woman should first have a complete physical and endocrinologic study. When all possible anatomic factors and endocrine disturbances have been eliminated as possible causes for the sterility, the patient should then be subjected to a complete psychiatric survey. Her entire life situation should be reviewed, conscious and unconscious conflicts should be identified and dealt with, and any factors inimical to healthy psychosexual functioning should be studied and eliminated. Sometimes an analysis of the personality structure uncovers important clues. The Rorschach test is very useful in this respect. An investigator well versed in the Rorschach technic can obtain a three dimensional view of the personality (psychogram) in much the same way as a stereoroentgenogram gives a three dimensional view of the skull. The presence of infantile emotional attitudes, excessive dependence or submissiveness, latent homosexual trends, deep anxiety, devastating conflicts and numerous other intrapsychic disorders can be revealed by a good Rorschach analysis.

The approach to the psychosomatic aspects of sterility must be eclectic, but our starting point should be the knowledge that women who are anatomically sound, who apparently want to bear children, who are economically and socially well able to do so, may be "functionally" sterile by reason of some neurotic disorder the significance of which even they themselves are not aware.

CONCLUSIONS

1. The neuroendocrine control of ovulation probably has its center in the pituitary gland.

2. The pituitary gland is in direct neural connection with the thalamus and hypothalamic centers, which are intimately concerned with the emotional life of man.

3. It is theoretically possible that emotional stimuli (psychologic repression) either are accompanied by or result in inhibition of pituitary function.

4. There is enough evidence in the psychiatric literature to support the concept that there is such an entity as "functional sterility."

5. Many women who are "functionally" sterile become fertile after they decide to adopt a child, after they have adopted children or after some psychiatric conflict has been solved.

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8. Benedek, T., and Rubenstein, B. B.: The Sexual Cycle of Women, Psychosomatic Medicine Monographs vol. III, Nos. I and II, Washington, D. C., National Research Council, 1942.

9. Grinker, Roy R.: A Comparison of Psychological "Repression" and Neurological "Inhibition," J. Nerv. & Ment. Dis. **89**: 765-781 (June) 1939.

Pharmacy and Prescribing.—Pharmacy is the art of preparing and compounding medicines, so as to exalt their virtues, obviate their ill qualities and render them less nauseous to the patient. The business of this is committed to the apothecary; but as the how it shall be done belongs wholly to the physician (for the officinal as well as the extemperaneous forms come from him) so it is necessary that he should be acquainted with it.—Heberden, William: An Introduction to the Study of Physic, New York, Paul B. Hoeber, Inc., 1929.

Clinical Notes, Suggestions and New Instruments

NODULAR NONSUPPURATIVE PANNICULITIS TREATED WITH PENICILLIN

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Pfeifer [1] in 1892 first reported the disease now known as relapsing febrile nodular nonsuppurative panniculitis, or Weber-Christian disease. Miller and Kritzler [2] in 1943 reviewed the clinical and pathologic findings in this disease with a review of 26 cases reported up to that date, adding a case report including autopsy findings. Since then V. de P. Larkin, De Sanctis and Margulis [3] reported another case and also reviewed the subject. Another case was reported by Spain and Foley [4] in 1944. Still another case was reported by Friedman [5] in January 1945. In all 30 more or less typical cases of nodular nonsuppurative panniculitis have been reported.

My purpose in this paper is to report a case of panniculitis treated with penicillin with apparent cure. Sulfonamides have been used in some of the cases reported with equivocal results. Sulfadiazine was used in treating this case with no apparent change in the course of the disease prior to the institution of treatment with penicillin.

REPORT OF CASE

History.—A soldier aged 23, admitted to Brooke General Hospital, Fort Sam Houston, Texas, on Jan. 18, 1945 as a transfer from McCloskey General Hospital, Temple, Texas, had had the usual childhood diseases, including mumps, with a left orchitis at the age of 10. Before entrance into the military service his health had always been good. His family history was essentially negative except that a maternal aunt had diabetes. He was inducted into the United States Army on July 17, 1942 and was perfectly well until March 19, 1944, when he was wounded in action in the Southwest Pacific area. He sustained a shell fragment wound of the left foot and left flank. These wounds were treated and healed. The injury to the left foot left a 1 inch scar on the medial and plantar surfaces of the left foot over the shaft of the first metatarsal. There was also a healed scar over the left lateral ilium and some atrophy with sensory changes of the left arm as a result of these injuries. He was evacuated to the United States and arrived at McCloskey General Hospital on July 15, 1944. He responded well to treatment. He showed complete recovery of the atrophy and sensory disturbances of the left arm and, aside from the aforementioned scars, was quite well. During the course of his hospitalization at McCloskey General Hospital he underwent an appendectomy on August 22 for acute appendicitis and a hemorrhoidectomy on November 15. He made an uneventful recovery from both of these operations. He was transferred to Brooke General Hospital Convalescent Unit on Jan. 18, 1945 for further convalescence.

On admission to the Convalescent Section, Brooke General Hospital, he had no complaints except for some disability of the left foot due to the plantar scar. On April 19 he was transferred to the Medical Service from the Convalescent Section because of the onset of subcutaneous nodules of the upper left arm and abdominal wall of four weeks duration accompanied by chills and fever occurring almost daily. These nodular areas were red, semifirm to touch and warmer than the surrounding skin, and they appeared to be fixed to the epidermis. They ranged in size from 1 by 1 cm. to 7.5 by 5 cm. In the course of the next three weeks he developed a total of 14 of these nodular areas involving both arms, both legs, the trunk, the abdomen and the back. His temperature was elevated daily up to 104 F. Associated with this he had frequent chills. Complete physical examination was essentially negative except for the presence of the nodules and a questionable palpable spleen.

Laboratory Examination.—Repeatedly the white blood cells showed a leukopenia as low as 3,200 with 50 to 75 per cent polymorphonuclears and moderate toxic granulation. The eosinophils were from 1 to 3 per cent. Repeated examinations for malaria were negative. The urine was normal. Routine agglutinations for typhoid, paratyphoid, typhus and brucellosis were negative. Blood culture on several occasions was negative. The sedimentation rate went as high as 21 mm. and returned to normal. X-ray examination of the sella turcica was normal, of the abdomen showed a definite enlargement of the spleen and of the chest was essentially negative.

Pathologic Examination.—Two biopsies were done. The first was essentially noncontributory. In the second biopsy, as reported by Lieut. Col. Harbert Davenport Jr., pathologist, Brooke General Hospital, the specimen consisted grossly of a segment of tissue measuring 4.5 by 3 by 1.5 cm. covered by an elliptic segment of skin which measured 4.5 by 1.5 cm. On section the epidermis appeared edematous. The outlets of the sweat glands were depressed. In the swollen subcutaneous tissue was a nodule which measured approximately 3 by 2 cm. The underlying fascia and adjacent adipose tissue were hemorrhagic. Microscopic examination revealed that the inflammatory process was limited almost entirely to the subcutaneous tissue. There was minimal cellular infiltration around the blood vessels and dermal appendages. Some of the fat lobules had undergone coagulation necrosis. Others were densely infiltrated with inflammatory cells, predominantly mononuclear, with varying numbers of neutrophils and occasional large phagocytes. The walls of the blood vessels were infiltrated with inflammatory cells, but this appeared to be part of the general reaction. The interlobular septums were edematous and showed less infiltration. In a few areas there were small, round, coccoid bodies which had the appearance of bacteria. The presence of multiple subcutaneous nodules of the chest, abdomen, forearms and legs, associated with chills and fever, relative leukopenia and the histologic findings were in keeping with, if not diagnostic of, relapsing, febrile, nodular, nonsuppurative panniculitis (Weber-Christian disease).

From April 26 until May 9, 1945 the patient received sulfadiazine 1 Gm. every four hours continuously. During this time he consistently had a daily temperature as high as 104 F. associated with chills and continued to have new nodular lesions. On May 10 penicillin therapy was instituted. The patient was given 20,000 units of penicillin every three hours intramuscularly for a period of fifteen days. He had a total dosage of 2,360,000 units of penicillin. After five days of penicillin his fever gradually dropped and during the sixth, seventh and eighth days of penicillin the highest temperature recorded was 100 F. After the fifth day of treatment he had no further new nodular lesions. On the ninth day of treatment his fever became normal and remained so during the course of his hospitalization. Shortly thereafter there was definite regression of all the skin lesions. They were no longer red or painful, and there seemed to be a tendency toward pitting of the skin over these lesions. However, after a period of thirty days from the institution of penicillin treatment the skin of the areas involved appeared normal. This patient was observed for a period of three and one-half months following disappearance of the nodules, during which time he had no recurrence of the lesions or any symptoms of panniculitis. He was separated from the service on the basis of his foot disability during the latter part of September 1945.

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COMMENT

A case of relapsing febrile nodular nonsuppurative panniculitis (Weber-Christian disease) was observed in a 23 year old soldier, the lesions proved by biopsy. Treatment with sulfadiazine was unsuccessful. The findings and symptoms were progressive until the institution of treatment with penicillin. Twenty thousand units of penicillin intramuscularly for a period of fifteen days with a total dosage of 2,360,000 units was used. Within eight days after institution of treatment the patient's temperature returned to normal and remained there. There were no further lesions noted. The nodules regressed and during a period of three and one-half months' observation there was no recurrence of symptoms or findings. The question arises whether the patient went into a natural remission of the disease or whether the disease responded to treatment with penicillin. In view of the fact that previous treatment for this condition has been unsatisfactory, it is felt that the penicillin in this case had a definite effect on the course of the disease and that further trial with this agent of therapy in the treatment of Weber-Christian disease would be advisable.

MYCOTIC ANEURYSM OF THE ULNAR ARTERY

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An infrequent but serious complication of subacute bacterial endocarditis is the formation of mycotic aneurysms. Before the present era of potent antibiotics subacute bacterial endocarditis alone was considered an almost universally fatal disease, and hence any complication arising from this dread illness was often viewed as only hastening the inevitable mortality. Today, however, more and more does the literature report cures of bacterial infections of the endocardium so that treatment of the complications of this disease can be attempted.

Aneurysms arising from infected emboli were recognized as early as 1851, when Koch [1] described one occurring in a man aged 22, who, while being treated for an endocarditis, died suddenly from the rupture of an aneurysm of the superior mesenteric artery. It was, however, Tufnell [2] in 1853 who is generally credited with being the first to recognize the relationship between emboli and aneurysm formation. He believed, however, that the outpouching of the vessel was due to the pressure produced behind the embolus. Ponfick [3] in 1873 showed that the aneurysm occurred at the site of the embolism and believed this to be a purely mechanical effect. In one of his earlier cases he described a pointed calcified embolus projecting through the arterial wall into the aneurysmal sac. He postulated, therefore, three conditions necessary for the production of an aneurysm of this type: (*a*) a barbed calcified embolus, (*b*) the enlodgment at the bifurcation of a vessel and (*c*) loose connective tissue surrounding the vessel, thereby providing little support for the wall. When confronted with a soft embolus as the cause of the aneurysm, he explained the damage as being due to constant pressure much the same as in decubitus ulcers.

Eppinger [4] in a classic monograph in 1887 made a careful study of the whole subject by applying reliable bacteriologic technic in establishing the relationship between the embolus at the site of aneurysm and the endocardial lesion. He suggested the term "embolomycotic" to imply the parts that the infection and the embolus played in the production of the aneurysm. Eppinger, however, believed that the infection was carried to the adventitia, causing an exudative periarteritis which later spread to involve the media and the intima. In this process portions of the elastic and muscular elements were destroyed by the bacteria and their toxins, and the remaining medial and adventitial elements were forced out by the intra-arterial pressure to form the aneurysmal sac. Today this is held as the course of events only when small infected emboli lodge in the vasa vasorum of the adventitia and are held there. Lewis and Schrager [5] believed that the infection begins in the lumen of the vessel; the process begins in the intima, reaches and destroys the internal elastic membrane and permits a distention of the wall. This not only explains embolomycotic aneurysms but can also explain the purely mechanical effect of Ponfick's barbed and pointed emboli. Gambaroff [6] suggested that the infected emboli may lodge in the vasa vasorum of the media and hence weaken the arterial wall by spread to the other coats, with destruction of elastic tissue.

Any artery may be affected, but in a review of the literature the aorta was found to be the most commonly affected, with next in frequency the abdominal vessels, namely the superior mesenteric, the hepatic and the splenic arteries. The multiplicity of embolomycotic aneurysms is striking. Stengel and Wolferth [7] in 1923 reviewed 217 cases, and more than one aneurysm was found in 49. Moreover, of these 217 cases 187 had evidence of endocardial disease, the remainder being associated with a variety of conditions.

Indeed, mycotic aneurysms may be differentiated from others in four ways, as suggested by Lewis and Schrager: 1. In developing at an earlier age. 2. In frequently being multiple, acute and chronic forms often occurring in the same individual. 3. In the frequent involvement of the visceral arteries. 4. In the tendency to remain small.

Fig. 1.—Expansile mass of ulnar artery.

REPORT OF CASE

On Dec. 6, 1944 a white man aged 22 was admitted to Gouverneur Hospital with the chief complaints of fever, loss of weight and loss of appetite. His past history revealed that he had had rheumatic fever at the age of 6 years. He was asymptomatic until 1940, when he developed "palpitations" of the heart. Strenuous activity was curtailed at that time and he was again symptom free until October 1944, when he became ill, complaining of nausea and vomiting. Following this he had

From the Gouverneur Hospital, medical service of Dr. S. N. Weber.

1. Koch, L.: Ueber das Aneurysma der Arteria meseraica, Inaug. Dissert., Erlanger, J. J. Barfus, 1851.
2. Tufnell, J.: The Influence of Vegetations on the Valves of the Heart in the Production of Secondary Arterial Disease, Dublin Quart. J. M. Sc. **15**: 371, 1853.
3. Ponfick: Ueber embolische Aneurysmen, nebst Bemerkungen über das acute Herzaneurysma (Herzgeschwür), Arch. f. path. Anat. **58**: 528, 1873.
4. Eppinger, H.: Pathogenesis (Histogenesis und Aetiologie) der Aneurysmen einschliesslich des Aneurysma equiverminosum, Arch. f. klin. Chir. **35**: 404, 1887.
5. Lewis, D., and Schrager, V. L.: Embolomycotic Aneurysms, J. A. M. A. **53**: 1808 (Nov. 27) 1909.
6. Gambaroff, G.: Ein Fall von Rupturaneurysma der Aorta infolge von infektiöser hematogener Mesaortitis, Beitr. z. path. Anat. u. z. allg. Path. **39**: 94, 1906.
7. Stengel, A., and Wolferth, C. C.: Mycotic (Bacterial) Aneurysms of Intravascular Origin, Arch. Int. Med. **31**: 527 (April) 1923.

joint pains, which were fleeting in character, and a feeling of profound weakness. In addition he had a spiking fever up to 103 F., anorexia and a weight loss of 18 pounds (8 Kg.).

On admission the patient was apprehensive, well nourished and well developed and appeared acutely ill. The pulse rate was 130 per minute, the temperature 102.8 F., the respiratory rate 20 per minute and the blood pressure 168/64. The essential physical findings were a heart enlarged to the left, with a regular sinus rhythm and a loud aortic diastolic murmur. A water hammer and capillary pulse were easily demonstrable. The spleen was not palpable. Numerous scattered petechiae were seen on both feet.

Blood culture on admission was positive, showing 10 colonies of Streptococcus viridans per cubic centimeter. Repeated the next day, this showed 12 colonies per cubic centimeter. The initial white blood cell count was 10,000, with 78 per cent polymorphonuclear leukocytes. The hemoglobin was 95 per cent. Penicillin therapy was started the day after admission, with 20,000 Oxford units intravenously as the initial dose and then 20,000 Oxford units intramuscularly every two hours thereafter. After fourteen days the blood culture was still positive in the broth, so an in vitro sensitivity test of the organism to the penicillin was carried out. This showed that 0.6 Oxford unit inhibited completely the growth of 2,500,000 streptococci isolated from the blood stream of the patient. Ordinarily in 100 cases thus studied an average of 0.05 to 0.15 Oxford unit was necessary to inhibit 2,500,000 organisms. The average dosage in the treatment of these cases of subacute bacterial endocarditis was about 10,000 Oxford units every two hours, or 120,000 Oxford units in twenty-four hours. Since in this particular in vitro test the organism proved to be approximately four times as resistant, it was felt that four times the dosage was necessary to control the infection. The treatment was consequently intensified so that the patient received 100,000 Oxford units intravenously each morning and 50,000 Oxford units every three hours. After two days of this intensive therapy the blood culture became negative and remained so. Five days later the patient began to complain of pain in his right elbow region. Examination found the right antecubital region hot, swollen and exceedingly tender. It was felt that this was either a thrombophlebitis due to the intravenous administration of penicillin or an embolic phenomenon arising from the heart. The intravenous dose of penicillin each morning was discontinued and the arm treated conservatively with heat, rest and elevation. Heavy sedation was necessary to control the symptoms. Finally, after several days had elapsed and the pain in the elbow was somewhat controlled, careful examination was possible and a pulsating, expansile mass became apparent (fig. 1). The diagnosis of a mycotic aneurysm of the right ulnar artery was made.

Fig. 2. — Mycotic aneurysm. A sacular structure 2.9 cm. by 2 cm. by 11 mm. There is an opening into the sac, the inner surface of which is seen to be clotted blood in one area and with a fairly smooth lining elsewhere.

Up until this time the patient had received twenty-nine consecutive days of penicillin therapy with a total of 10,225,000 Oxford units. A surgical consultation was requested and the diagnosis was confirmed. The penicillin was restarted prophylactically (12,500 Oxford units every three hours) and an operation performed. The aneurysm was found to be located beneath the deep head of the pronator teres muscle. The artery was ligated above and below and the aneurysm was removed (fig. 2). The patient made an uneventful recovery, and the return of motion of the hand and arm has been satisfactory. Pathologic section has proved the aneurysm to be mycotic in origin (figs. 3 and 4).

A careful follow-up of this patient has been carried out over a period of several months. He has been placed on a prophylactic course of 1 Gm. of sulfadiazine daily. He has gained weight, returned to his job and resumed normal activity. Repeated blood cultures since his discharge from the hospital have been completely negative. Frequent blood counts have been within normal limits.

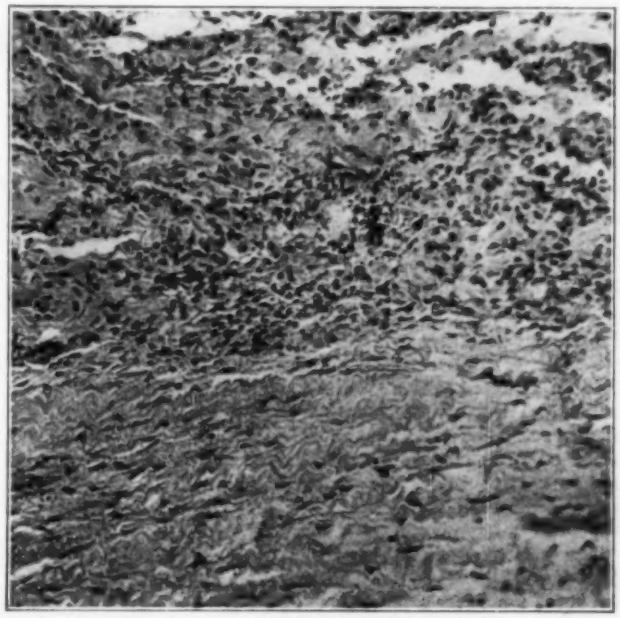

Fig. 3 —Section of the mycotic aneurysm showing extensive inflammatory reaction due to infection of the vessel wall.

CONCLUSION

In a case of subacute bacterial endocarditis there developed a mycotic aneurysm during the course of penicillin therapy. The endocarditis was cured with massive doses of penicillin, and the aneurysm was successfully removed by prompt surgical intervention. We feel that a successful surgical result in this case was in no small measure dependent on the employment of adequate penicillin therapy.

Fig. 4.—Section of the mycotic aneurysm showing that rupture has caused extensive hemorrhage into the surrounding muscle tissue.

22 East Thirty-Sixth Street, New York 16.

ACUTE ACETONE POISONING FROM LEG CASTS OF A SYNTHETIC PLASTER SUBSTITUTE

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Cases of acute acetone poisoning reported in the literature are indeed rare, so much so that it was felt that perhaps this case report might be justified.[1] We feel that this complication in varying degree must be of considerable more frequency than the paucity of reported cases would lead one to believe at first thought.

REPORT OF CASE

F. R., a white girl aged 10 years, entered Gillette State Hospital on March 3, 1945 with the diagnoses of (*a*) cerebral spastic paraplegia and (*b*) mild hydrocephalus. On admission the urine was straw colored, clear and acid in reaction, with a specific gravity of 1.021. There were no casts, sugar nor albumin reported, although a very few white blood cells were present. The blood work-up revealed a hemoglobin of 82 per cent, a red blood cell count of 4,520,000 and a white blood cell count of 7,250 distributed as follows: polymorphonuclears 63 per cent, lymphocytes 36 per cent and monocytes 1 per cent. The bleeding time was 1 minute, and the clotting time was 3 minutes 5 seconds.

The patient's course in the hospital was good, and she gained weight, was active and cooperated well in her physical therapy. On March 20 she had bilateral adductor tenotomies and obturator neurectomies performed with an uneventful convalescence postoperatively. On May 25 she came down with chickenpox, from which she recovered completely and uneventfully. On August 14 bilateral posterior capsulotomies were performed on her knees to straighten them. She had an uneventful convalescence from the operation and rapidly regained her appetite and previous activity. On August 23 she began standing and with the recovery of her balance began to learn to walk correctly, which she was doing well by August 30. At this time it was felt that the plaster of paris casts (bilateral long leg casts) in which the patient was walking were perhaps retarding her physical gains because of their weight. It was therefore decided to remove them and to apply long leg casts made of a commercial preparation consisting of a material lighter than plaster of paris and composed of polymerized vinyl acetate, pyroxylin, chemically pure boric acid, chemically pure acetone (solvent-evaporator agent) and surgical gauze.

On September 1 the plaster of paris casts were removed; the Pyoktanin sutures were brushed from the incisions and the wounds were examined. The incisions were found to be well healed by primary intention, without any open areas. New long leg casts of the aforementioned synthetic material were applied over a double layer of stockinet, according to directions furnished by the company. The casts were smoothed by application of a commercial lacquer, also furnished by the company and consisting of primarily an acetone solution.

The patient was returned to the ward and placed before an open window with electric fans blowing over the casts to assure adequate evaporation and ventilation. The patient felt well the rest of the day, although that evening she was somewhat sleepy and lethargic. During the night her sleep was fitful and she tossed about a great deal. There were several emeses during the night and early the next morning consisting of typical coffee colored material. This was strongly positive when analyzed for blood. The patient felt better during the morning and retained cold ginger ale and cold milk fairly well. Fluids were given as the patient desired. Owing to the improvement in the patient's clinical condition the casts were polished that afternoon (September 2) by means of the aforementioned commercial lacquer furnished for the purpose. Ventilation by means of the open window and electric fans was maintained that afternoon and evening. Late that afternoon the patient gradually became worse and by evening was nearing a comatose condition, clinically. Her breathing was labored and of the Kussmaul type. There was acetone on her breath; her mouth and throat were dry; the tongue was coated. Urinalysis at this time revealed an acid reaction, albumin a trace, sugar 2 plus, acetone 4 plus and occasional white blood cells and rare red blood cells. The blood pressure was not significantly changed. The temperature was slightly elevated, having gone up to 99.2 F. The pulse rate was elevated to 120 per minute; respirations were somewhat increased. The diagnosis of acute acetone poisoning was made and supportive treatment was begun. An intravenous injection was started consisting of 500 cc. of 10 per cent glucose in isotonic solution of sodium chloride. The casts were split and removed. Examination of the underlying skin revealed no urticaria, wheals or any other signs of idiosyncrasy or irritation. The incisions were, as before, completely healed without any signs of irritation or reaction. More fluids were added to the intravenous injection throughout the remainder of the night, so that by late the next morning 2,000 cc. had been administered. Urinalysis late that night revealed an acid reaction, sugar 3 plus, albumin a trace and acetone 2 plus.

The next morning (September 3) the patient was clinically much improved, being more responsive and alert. Questioning revealed that she still felt weak and listless. Urinalysis at noon revealed acid reaction, albumin negative, sugar a trace and acetone a trace. Oral fluids were forced all this day and for several days following. The patient took a soft diet well, and her condition rapidly returned to normal. The remainder of her convalescence was uneventful. There have been no recurrences of any similar nature, and her laboratory reports since have been normal up to the present time. No similar casts of this material have been applied to this patient. Patch test of the offending material was applied Feb. 4, 1946 and was reported negative at twenty-four and forty-eight hours.

COMMENT

Analysis of this case brings to light the fact that the reaction must have been attributable to acute poisoning by acetone, the solvent-evaporator agent used in the commercial material. Ketosis may be the result of insufficient oxidation of ketone bodies with accumulation secondary to a deranged metabolism or may be the direct result, as in this case, of prolonged accumulative absorption directly of the ketone bodies (one of which is acetone) to the point of pathologic limits.[2] It is known that considerable quantities of ketone bodies may be destroyed in the muscles, and it is only when the quantities entering the blood exceed certain limits that ketosis results.[3] Thus a bedfast patient or one restricted in activity is more susceptible by nature of decreased ability to destroy the ketone bodies through muscular exercise.

Further, considerable evidence is accumulating that the ketone bodies do not require carbohydrate for their metabolism (the old idea expressed by the statement that "fats burn in the fire of carbohydrates").[4] Modern experimenal evidence points out that carbohydrates have no ketolytic effect, that their effect on ketosis is purely antiketogenic.[5] Thus there is no modern rationale for the administration of large quantities of glucose or glucose and insulin in the treatment of the condition.

It is of interest in this case, as differentiated from the case reported by Strong,[1] that there were no skin reactive manifestations under the synthetic casts, thereby supporting the general contention that the acetone was absorbed by way of the lungs. The presence of the hemorrhagic esophagitis in this case in the absence of any introduced foreign bodies or trauma (in Strong's case a Levine tube was required) strongly

1. Strong, G. F.: Acute Acetone Poisoning, Canad. M. A. J. **51**: 359-362 (Oct.) 1944; abstr. J. A. M. A. **126**: 1116-1117 (Dec. 23) 1944. Schumann, H., and Klotzbücher, E.: Eine neue Leberfunktionsprobe, Klin. Wchnschr. **19**: 1101-1102 (Oct. 26) 1940.

2. Cecil, R. L.: A Textbook of Medicine, ed. 5, Philadelphia, W. B. Saunders Company, 1942.

3. Neufeld, A. H., and Ross, W. D.: Blood Ketone Bodies in Relation to Carbohydrate Metabolism in Muscular Exercise, Am. J. Physiol. **138**: 747-752 (April) 1943. Koehler, A. E.; Windsor, Emanuel, and Hill, Elsie: Acetone and Acetoacetic Acid Studies in Man, J. Biol. Chem. **140**: 811-826 (Sept.) 1941.

4. Haggard, H. W.; Greenberg, L. A., and Turner, J. M.: The Physiological Principles Governing the Action of Acetone Together with Determination of Toxicity, J. Indust. Hyg. & Toxicol. **26**: 133-151 (May) 1944. Koehler, Windsor and Hill.[3] Somogyi and Weichselbaum.[5]

5. Somogyi, Michael, and Weichselbaum, T. F.: Ketone-Sparing Effect of Glucose, J. Biol. Chem. **145**: 567-574 (Oct.) 1942. Koehler, Windsor and Hill.[3]

suggests a toxic manifestation of the acute acetone poisoning state.

It is concluded that this patient suffered an acute acetone poisoning with resulting ketosis and hemorrhagic esophagitis from the prolonged accumulative inhalation of the acetone solvent-evaporator agent used in the commercial synthetic cast material. The condition is easily recognized and readily responds to treatment of a supportive nature. This report is not intended to condemn in any way the material used but rather to bring before the medical profession the fact that this condition can occur, and to stimulate its early recognition and prevention, perhaps bringing to light additional cases of similar origin, as yet unreported.

1003 Ivy Avenue East, St. Paul 6.

Council on Industrial Health and Council on Pharmacy and Chemistry

ALUMINUM IN THE PREVENTION AND TREATMENT OF SILICOSIS

The Council on Industrial Health and the Council on Pharmacy and Chemistry of the American Medical Association have authorized publication of the following report on the use of aluminum in the prevention and treatment of silicosis. Since this means of therapy is controlled by patent and can be used only by licensees, studies will be continued by the two councils into this phase of the subject. Further reports will be issued as indicated.

CARL M. PETERSON, M.D.
Secretary, Council on Industrial Health.
AUSTIN E. SMITH, M.D.
Secretary, Council on Pharmacy and Chemistry.

The dissemination of reports on the effects of aluminum powder in the prevention and treatment of silicosis has aroused widespread interest and a demand for an authoritative statement regarding its value. At the present time the following statement would seem to be warranted; it is subject, however, to such modification as future knowledge and experience may indicate.

1. In experimental animals the *prophylactic* use of aluminum inhibits the toxic action of relatively pure quartz.

2. In man, industrial dust exposures often involve mixtures of various minerals in addition to quartz and other environmental variables to which experimental animals are not subject. Therefore human silicosis usually develops more slowly and is often modified in type. Only prolonged unbiased observation, with adequate control cases, will demonstrate whether the prophylactic results obtained with animals are applicable to man.

3. Animal experiments have demonstrated that administration of high concentrations of amorphous hydrated alumina unfavorably influences resistance to tuberculosis. While this result has not yet been reported for metallic aluminum, caution in the application of all aluminum therapy to human beings is recommended.

4. The use of aluminum might appear as an easy short-cut to healthful working conditions, thus saving large expenditures for ventilation and other control methods. Actually there is no substitute for the accepted methods of dust control.

5. If industry indiscriminately treats all employees with aluminum dust, there may be aggravation of tuberculosis or other pulmonary conditions.

6. The *therapeutic* use of aluminum in man appears to relieve symptoms in a very small number of cases in which silicosis develops rapidly. Experience in some groups is more favorable than in others.

7. In view of these considerations it is recommended that the general application of aluminum therapy in industry be delayed until adequately and impartially controlled clinical observation demonstrates its effectiveness in preventing or alleviating silicosis in man. In the meantime, there should be no slackening in the control measures that have been found effective in reducing the incidence of dust diseases in industry.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its actions will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

TUAMINE SULFATE.—2-aminoheptane sulfate.—$C_{14}H_{36}O_4N_2S$.—M. W. 328.51.

The formula of 2-aminoheptane sulfate is:

$$(H_3CCH_2CH_2CH_2CH_2\underset{\displaystyle NH_2}{\underset{|}{C}}HCH_3)_2.H_2SO_4$$

Actions and Uses.—A 1 per cent solution of this compound exceeds the vasoconstrictive effects of a similar concentration of ephedrine, while 0.5 per cent has been found to produce about equal vasoconstrictor action. The duration of effect, when compared to that of ephedrine, is prolonged.

Dosage.—A 1 per cent solution may be applied to the mucous membranes of infants and adults by spray, dropper or tampon and is usually adequate for routine treatment. A 2 per cent solution, best applied by pledgets of cotton, may be used for operative procedures, diagnostic examination and to meet other special circumstances. For displacement therapy, a 0.2 per cent solution can be used.

Tests and Standards.—

Tuamine sulfate occurs as a white, odorless powder, which is readily soluble in water. The *pH* of a 1 per cent solution is about 5.4.

Dry 1 Gm. of tuamine sulfate, accurately weighed, to constant weight at 100 C.: the loss in weight does not exceed 1 per cent.

Ignite about 0.5 Gm. of tuamine sulfate, accurately weighed: the amount of residue is not more than 0.1 per cent.

Dissolve 1.2 Gm. of tuamine sulfate in 25 cc. of water to which 1 Gm. of potassium cyanate has been added. Heat on a steam bath for one hour; cool, filter, wash the crystals with distilled water and dry at 100 C.: the derivative melts at 127-129 C.

Dissolve about 0.2 Gm. of tuamine sulfate, accurately weighed, in 100 cc. of distilled water; add 1 cc. of hydrochloric acid and heat; add 20 cc. of barium chloride solution dropwise to the boiling solution. Allow the mixture to stand four hours and then filter through a previously tared Gooch crucible. Wash the precipitate until chloride-free, dry and finally ignite to constant weight: the weight of barium sulfate found is equivalent to a sulfate content of not less than 28.5 per cent nor more than 30 per cent.

The nitrogen content, as determined by the Dumas method, is not less than 8.35 per cent nor more than 8.75 per cent.

Dilute about 1 Gm. of tuamine sulfate, accurately weighed, with water to the mark of a 25 cc. volumetric flask. Transfer 5 cc. of the solution to an ammonia distillation apparatus; add 3 cc. of 40 per cent sodium hydroxide solution and distil the amine into 20 cc. of tenth-normal hydrochloric acid until 25 cc. of distillate has been collected. Titrate the acid solution with tenth-normal sodium hydroxide, using methyl red as the indicator. Each cubic centimeter of tenth-normal acid is equivalent to 0.01643 Gm. of tuamine sulfate: the 2-aminoheptane sulfate content is not less than 96.5 per cent.

ELI LILLY & CO., INDIANAPOLIS

Solution Tuamine Sulfate, 1%: 30 cc. and 475 cc. bottles. Each 100 cc. contains tuamine sulfate 1.0 Gm., potassium phosphate monobasic 0.68 Gm., sodium chloride 90 mg., methyl parahydroxybenzoate 26 mg. and propyl parahydroxybenzoate 14 mg.

Solution Tuamine Sulfate, 2%: 60 cc. and 475 cc. Each 100 cc. contains tuamine sulfate 2.0 Gm., potassium phosphate monobasic 0.68 Gm., methyl parahydroxybenzoate 26 mg. and propyl parahydroxybenzoate 14 mg.

Solution Tuamine Sulfate 1 per cent and 2 per cent.—

Use 25 cc. of the tuamine sulfate solution for the reaction with potassium cyanate as described in tests and standards for tuamine: the product melts at 126-127 C.

Transfer 5 cc. of the solution to an ammonia distillation apparatus. Add 3 cc. of 40 per cent sodium hydroxide solution to the reaction chamber and distil the amine into 10 cc. of tenth-normal hydrochloric acid. Titrate the acid solution with tenth-normal sodium hydroxide, using methyl red as the indicator. Each cubic centimeter of tenth-normal hydrochloric acid is equivalent to 0.01643 Gm. of tuamine sulfate: the 2-aminoheptane sulfate content is not less than 95 per cent nor more than 105 per cent of the stated amount.

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SATURDAY, APRIL 27, 1946

VIRULENCE OF PENICILLIN RESISTANT BACTERIA

Most investigators are agreed that organisms may develop resistance to penicillin both in vivo and in vitro. They disagree, however, on the concurrent effects on virulence. Schmidt and his associates [1] of Christ hospital, Cincinnati, made serial transfers of pneumococci in mice treated with inadequate therapeutic doses of penicillin. The highest concentration of penicillin permitting visible growth of the parent culture in vitro was 0.4 Oxford unit per cubic centimeter. After the fifth serial passage, growth occurred when the penicillin concentration was 1.4 units per cubic centimeter. Tests of virulence in untreated control mice suggested that there was no accompanying increase or decrease in virulence.

McKee and her associates [2] of the Squibb Institute for Medical Research, however, increased the resistance of both streptococci and pneumococci to penicillin by serial transfer in nutrient broth containing increasing concentrations of penicillin. They found that this increased resistance to penicillin was always accompanied by a decrease or even complete loss of mouse virulence. Serial passage of the resulting avirulent strains in normal mice failed to restore the lost virulence.

Miller and Bohnhoff [3] of the Department of Medicine, University of Chicago, have attempted a detailed confirmation or disproof of these changes in virulence with seven strains of meningococci. The natural resistance of a typical strain was found to be sufficient to allow its growth in the presence of 0.3 Oxford unit of penicillin per cubic centimeter. By serial transfer on blood agar plates containing increasing amounts of penicillin the resistance of this strain was increased so that it would grow in the presence of 41 Oxford units per cubic centimeter. The minimum lethal dose of the initial strain was less than 10 meningococci. By the time the penicillin resistance had reached 5 units per cubic centimeter the minimum lethal dose had increased to the neighborhood of 100 meningococci, a 90 per cent decrease in mouse virulence. As soon as the resistance to penicillin reached 18 units per cubic centimeter one billion meningococci failed to kill mice. The total loss of virulence could not be restored by mouse passage. Six of the seven strains, however, retained considerable virulence beyond the 18 unit penicillin resistance stage. Mice infected with an intermediary, 14 unit penicillin resistant strain, required 600 units of penicillin for a cure, or fifteen to thirty times the effective curative dose for the initial parent strain.

Miller's data suggest that under ordinary clinical conditions inadequately treated meningococci usually retain a sufficient amount of their original virulence to be of epidemiologic interest.

1. Schmidt, L. H., and Sesler, Clara L.: Development of Resistance to Penicillin by Pneumococci, Proc. Soc. Exper. Biol. & Med. **52**: 353 (April) 1943.
2. McKee, Clara M., and Houk, Carol L.: Induced Resistance to Penicillin of Cultures of Staphylococci, Pneumococci and Streptococci, Proc. Soc. Exper. Biol. & Med. **53**: 33 (May) 1943.
3. Miller, C. P., and Bohnhoff, Marjorie: Proc. Soc. Exper. Biol. & Med. **60**: 354-356 (Dec.) 1945.

THE BONE MARROW IN EXPERIMENTAL FOLIC ACID DEFICIENCY

The recent important discovery of the striking value of pure folic acid in the treatment of various human macrocytic anemias [1] has added interest and significance to experimental studies on this new B vitamin. One problem of immediate importance is the type of alterations produced in the bone marrow in folic acid deficiency and the effect of administration of folic acid on these changes. Further reason for the fundamental importance of studies of the bone marrow is the fact that folic acid deficiency in the experimental animal may produce not only an anemia but also a severe granulocytopenia.[2]

Bone marrow studies have recently been made [3] in rats fed a diet deficient in folic acid, due presumably to the addition of 1 per cent succinylsulfathiazole, which inhibits bacterial synthesis of folic acid ("Lactobacillus casei factor") in the intestine. Leukopenia, granulocytopenia and less frequently anemia developed regularly in the rats, and the administration of pure folic acid either prevented or corrected the dyscrasias. The bone marrow of the animals deficient in folic acid showed progressive hypoplasia with general cellular depletion, especially of the myeloid series. The erythroid series was also usually depleted even though distinct anemia was not found. The administration of folic acid produced a striking immediate response discernible within two to three days both in the bone marrow and in the peripheral blood, manifested by an increase in hematocrit and in total leukocyte and polymorphonuclear, eosinophil, lymphocyte and normo-

1. Spies, T. D.: Effect of Folic Acid on Persons with Macrocytic Anemia in Relapse, J. A. M. A. **130**: 474 (Feb. 23) 1946. Darby, W. J.; Jones, E., and Johnson, H. C.: Science **103**: 108 (Jan. 25) 1946.
2. Kornberg, A.; Daft, F. S., and Sebrell, W. H.: Proc. Soc. Exper. Biol. & Med. **58**: 46 (Jan.) 1945. Day, P. L., and others: J. Biol. Chem. **157**: 423 (Jan.) 1945.
3. Endicott, K. M.; Daft, F. S., and Ott, Maurene: The Bone Marrow in "Folic Acid" Deficiency, Arch. Path. **40**: 364 (Nov.-Dec. 1945).

blast counts. The response of the bone marrow was a spectacular myeloid proliferation and erythroid hyperplasia. Later the erythroid series was frequently crowded out by myeloid hyperplasia. The marrow subsequently returned to normal after a temporary overcompensation.

These studies emphasize the profound fundamental effect of folic acid on hemopoiesis and leukopoiesis and invite further investigations on the mode of action of this substance in blood formation.

FINANCIAL SUPPORT OF MEDICAL SCHOOLS

The war dealt a serious blow to the quality of medical education. The failure of the Selective Service System to provide for the training of scientists has already resulted in a serious deficiency of instructors, particularly in preclinical subjects. The rosters of candidates for Doctor of Philosophy degrees in our larger universities have been largely nonexistent for some four or five years.

A further threat to the quality of medical education lies in financial developments involving the budgets of our medical schools. Dr. Frank E. E. Germann [1] pointed out in a recent issue of *Science* that the current salaries in effect for instructors in science are such as to make it virtually impossible to attract qualified men and women to these institutions as teachers. He says "A small number of our highly endowed educational institutions have been able to hold and attract outstanding scholars because of their higher salary scales, but the average private or state-supported institution has been forced into mediocrity." He asks "What future can we promise young men and women holding pre or postdoctoral fellowships at $1,800 to $3,000 when we still offer $2,000 for assistant professors and require that they have the doctorate degree? What chance do we have to secure a competent teacher in science when a full professor, after thirty years of service, may never reach a salary of $4,000?"

The failure to provide adequate salaries can be attributed in part to the decreased endowment income of recent years, which, estimates indicate, has lost the medical schools about one third of their endowed income. Other factors are operating to reduce funds available to pay teachers in medical school. Faculties are being increased in numbers with the return of men who have been on leave for military or other government assignments. Income from fees for tuition will decrease, sharply in some instances, because the deceleration of the medical curriculum will provide fees to the school for only three fourths of the calendar year instead of the entire year. Fees collected will also be reduced by reductions in enrolments. State schools will receive smaller sums because the Army and Navy medical school programs paid out-of-state tuition fees which are often considerably greater than the fees charged residents of the state in normal times. With the termination of the military medical school programs these state universities will be returning to the normal lower fee schedule.

As a result of these developments a serious lowering of standards in medical education may be anticipated. Every means must be explored to combat such tendencies. Increased endowments must be sought, perhaps especially from industry, which benefits largely from improvements in science instruction and research. The financial structure of most of our states is now such that considerably increased sums could be employed in medical education without greatly taxing state resources. Bills now pending before Congress provide primarily for the support of scientific research and training fellowships. Little if any consideration is given to the equally important financial strengthening of our whole structure of medical education. An annual budget of $350,000 for a small medical school may be the minimum goal which should be sought by all medical schools. Unfortunately, an appreciable number of our medical schools has not reached this minimum standard.

1. Germann, Frank E. E.: Science **103**: 68 (Jan. 18) 1946.

MULTIPLE BACTERIOSTASIS

A new method of preventing the development of acquired drug resistance in pathogenic micro-organisms is suggested by Carpenter and his associates [1] of the Department of Bacteriology, University of Rochester. Investigators studied in vitro the acquired resistance of five originally nonresistant strains of gonococcus against four bactericidal agents. The four bacteriostatic agents were sodium sulfathiazole, rivanol lactate, promin and penicillin. These represented four different types of antibiotic agents and were tested both singly and in combination.

The five gonococcus strains were grown in a Douglas broth plus 5 per cent rabbit serum with gradually increasing concentrations of each agent or combination. All cultures were transferred every forty-eight hours for four months to the same concentration of the drug or combination in which they were growing and to a greater concentration. The degree of acquired drug resistance varied with individual strains. Thus one strain acquired a 1,280-fold resistance to sodium sulfathiazole by the end of four months. A second strain acquired but a 17-fold drug resistance. The average for all five strains was a 700-fold increase in sulfathiazole resistance. The average acquired resistance to rivanol lactate was 80-fold and to penicillin 182-fold. With promin the increase was but 9-fold.

A quite different result was obtained when three or more of these drugs were mixed, each of the drugs

1. Carpenter, C. M.; Bahn, J. M.; Ackerman, H., and Stokinger, H. E.: Proc. Soc. Exper. Biol. & Med. **60**: 168 (Oct.) 1945.

being used in a third or a fourth of the maximum concentration permitting growth. Thus with a mixture of sodium sulfathiazole, ravinol lactate and promin the average acquired resistance was but 10-fold. With the addition of penicillin the increase in drug resistance was reduced to zero. Under these conditions penicillin completely inhibited the development of acquired resistance to the triplicate bacteriostatic agent. In the same mixture the gonococcus did not acquire a penicillin resistance.

Whether or not a similar mutual inhibition of acquired drug resistance takes place under clinical conditions has not yet been determined. Carpenter does not suggest a theory to account for this mutual inhibition. He has no doubt discovered a basic biologic phenomenon that may in time prove to be of major clinical interest.

THE ANEMIA OF CHRONIC INFECTIONS

The frequent occurrence of anemia during chronic infections, such as empyema, endocarditis and osteomyelitis, is well known. Also clinical experience has shown that this type of anemia is almost always refractory to the usual therapeutic measures. The administration of iron, either orally or intravenously, for example, has little beneficial effect.

Recently a careful study of the utilization of iron in a series of patients with chronic infections has been reported by Wintrobe and his associates.[1] Analyses showed that the plasma iron values of the patients were consistently much lower than normal, the average for 19 patients being 29 micrograms per hundred cubic centimeters in contrast to an average of 120 micrograms per hundred cubic centimeters for 20 normal persons. The oral administration of iron to these patients did not result in a significant increase in the iron content of the plasma, in sharp contrast to the results in normal persons. There was an accompanying increase in serum copper values, a phenomenon observed in a number of types of anemia in which there is an increased demand for iron for hemoglobin regeneration.[2] Further analyses [1] demonstrated that both the erythrocyte protoporphyrin and urinary coproporphyrin values were higher than normal in the patients with infections. The Utah investigators therefore advance the explanation that the anemia of chronic infections is a result of a failure in the utilization of iron for hemoglobin regeneration during chronic infections owing probably to some unknown "persistent and urgent demand for iron to fulfil some function in relation to infection which has a greater priority for iron than hemoglobin formation." In support of the latter explanation it is pointed out that there is an accumulation and fixation of iron in inflammatory tissue [3] and in the reticuloendothelial system of mice during infections.[4]

Continued experimental studies of this thesis should prove of importance in elucidating the etiology of the anemia of chronic infections and in pointing the way to a more rational adequate therapy.

1. Cartwright, G. E.; Lauritsen, M. A.; Humphreys, L.; Jones, P. J.; Merrill, I. M., and Wintrobe, M. M.: Science **103**: 72 (Jan. 18) 1946.
2. Sachs, Adolph; Levine, V. E., and Fabian, A. A.: Copper and Iron in Human Blood, Arch. Int. Med. **55**: 227 (Feb.) 1935.
3. Menkin, Valy: J. Exper. Med. **51**: 879 (June) 1930. Menkin, Valy, and Menkin, M. F., ibid. **53**: 919 (June) 1931.
4. Schafer, K. H.: Klin. Wchnschr. **19**: 979, 1940; **22**: 98, 1943.

Current Comment

HEPARIN

Increased interest in the use of heparin for the prevention and treatment of thrombosis has developed with the availability of preparations sufficiently pure to permit their parenteral introduction. The development of the barium and sodium salts of heparin and of improved bioassay methods have aided in the production of standardized heparin preparations better than those previously obtainable. While the anticoagulant action of heparin appears quickly after its administration, this effect fades within a few hours, in contrast to the delayed but prolonged activity of the other anticoagulant, dicumarol. Repeated intravenous injections of solutions of heparin or continued venoclysis are therefore essential when an anticoagulating effect extending over days or weeks is desired. Such effects are required in the treatment of bacterial endocarditis, phlebothrombosis, thrombophlebitis, postoperative pulmonary embolism, frostbite and repair of vascular injury.[1] This method of heparin administration is cumbersome, expensive and not free from serious complications (hemorrhages) through inadvertent overdosage (Katz and Elek [1]), and Loewe and Rosenblatt [2] recently introduced a new method of subcutaneous injection of heparin by incorporating this agent into Pitkin's menstruum, consisting of gelatin, dextrose, glacial acetic acid and water, which, it is claimed, achieves a consistent, retarded and equal release of the anticoagulant from the vehicle into the tissue. Heparin, when dissolved in this medium, should not be given oftener than every two to three days to insure adequate heparinization, which is accomplished when the coagulation time of the blood fluctuates between thirty and sixty minutes. Ephedrine may be added to the vehicle to retard further the absorption of the anticoagulant from its deposit. Loewe and his associates have used this medium in an appreciable number of cases of bacterial endocarditis, phlebothrombosis and frostbite without encountering

1. Katz, L. N., and Elek, S. R.: Combined Heparin and Chemotherapy of Subacute Bacterial Endocarditis, J. A. M. A. **124**:149 (Jan. 15) 1944. McLean, Jay; Meyer, B. B. M., and Griffith, J. M.: Heparin in Subacute Bacterial Endocarditis, ibid. **117**: 1870 (Nov. 29) 1941. Loewe, Leo: The Combined Use of Penicillin and Heparin in the Treatment of Subacute Bacterial Endocarditis, Canad. M. A. J. **52**: 1, 1945. Loewe, Leo; Rosenblatt, Philip; Greene, H. J., and Russell, Mortimer: Combined Penicillin and Heparin Therapy of Subacute Bacterial Endocarditis, J. A. M. A. **124**:144 (Jan. 15) 1944. Loewe, Leo: Venous Thromboembolic Disease, ibid. **130**: 386 (Feb. 16) 1946. Lange, K. and Loewe, L.: Subcutaneous Heparin in the Pitkin Menstruum for the Treatment of Experimental Human Frostbite. Surg. Gyn. & Obst. **82**:256 (March) 1946.
2. Loewe, Leo, and Rosenblatt, Philip: A New Practical Method for Subcutaneous Administration of Heparin, Am. J. M. Sc. **208**: 54 (July) 1944.

apparently any untoward reactions attributable to the heparin. Future investigations made in a larger number of cases however must show whether or not this good record can be maintained. The amount of fat tissue, and thus the degree of vascularization at the site of deposit, influences the speed of absorption of the heparin from the menstruum into the blood. A similar effect may be exerted by the massaging action of contracting muscles or by outside pressure occurring in changes of position of the patients under treatment. Some difficulties also may be confronted in checking the untoward reactions elicited by overdosage or by excessively speedy absorption of the heparin. Injection of whole blood or protamine to neutralize the free heparin and the compression of the tissue surrounding the depot, or the application of cold to the site of deposition so as to slow the absorption of the heparin, has been recommended as a countermeasure. Whether or not such procedures are adequate in all cases to overcome quickly serious hemorrhagic tendencies remains a matter of further study.

RADIOACTIVE PHOSPHORUS AS A THERAPEUTIC AGENT

An extensive study of radioactive phosphorus as a therapeutic agent has been carried out in the Mallinckrodt Institute for Radiology and the department of internal medicine of the Washington University, St. Louis. The recent report [1] on results of this study proves conclusively that radioactive phosphorus (P^{32}) "emits beta-rays capable of producing a profound radiation effect on tissues" yet can be administered without harm to the patient. P^{32} especially affects the bone marrow; leukopenia, thrombocytopenia and anemia may be produced. The final dosage in any case must be determined by blood and marrow examinations and by general clinical observations. The standardization of the assay of radioactive phosphorus is discussed by Kamen.[2] The therapeutic results obtained with radioactive phosphorus in myelogenous and lymphatic leukemia were much the same as those obtained with x-rays but without any radiation sickness. Hodgkin's disease, lymphosarcoma, reticulum cell sarcoma and multiple myeloma do not respond to P^{32} as favorably as to x-rays. As yet evidence has not been obtained of any therapeutic effect by P^{32} on mycosis fungoides, xanthomatosis, melanoma, Ewing's tumor, carcinoma of the breast or of the gallbladder, or monocytic leukemia. The main result of a positive nature from the work at Washington University is the confirmation in 30 cases that radioactive phosphorus "is probably the best therapeutic agent available at the present time for polycythemia vera." Almost complete remissions are obtainable, but the effect on the duration of life is not yet known. When the diagnosis has been made, 3.5 to 4 millicuries of P^{32} is injected intravenously. If the count remains above 6 million, a second injection of 1 to 3 millicuries is given in about ninety days. In the meantime, if it seems advisable, 500 cc. of blood may be removed daily until the count comes down to 6 million or so. Many patients do not require a second injection. Evidently P^{32} has a selective action on erythropoiesis. By trial and error progress has been made in the treatment of disease with a substance made radioactive by means of the cyclotron.

1. Reinhard, E. H.; Moore, C. V.; Bierbaum, Olga S., and Moore, Sherwood: Radioactive Phosphorus as a Therapeutic Agent, J. Lab. & Clin. Med. **31**: 107 (Feb.) 1946.
2. Kamen, Martin D.: Remarks on the Assay of Radioactive Phosphorus, J. Lab. & Clin. Med. **31**: 276 (Feb.) 1946.

NEW FACTOR PROPOSED IN GENESIS OF GOITER

Lack of iodine may not be the sole cause of simple goiter. Recently Greenwald [1] reviewed the evidence regarding the early history of goiter in the Americas, in New Zealand and in England. Examination of early reports, he says, does not disclose the presence of goiter in New Zealand or in the Americas prior to the appearance of Europeans. In each instance the earliest reports on the occurrence of goiter in these areas were among white men and women; therefore Greenwald concluded that endemic goiter did not exist in the natives of the Americas or New Zealand until Europeans arrived. He also discusses the variation in the incidence of goiter and epidemic outbreaks as reported in the literature. As a result of this review he suggests that one factor in the production of goiter may be a biologic agent, possibly a virus, which was brought into Derbyshire, England, from Italy in 1717 with the introduction of silk throwing and into the Americas and New Zealand by white immigration. Although this is an interesting hypothesis, the evidence thus far presented is hardly convincing; most epidemiologists will require more critical evaluation before accepting it.

1. Greenwald, Isidor: The Early History of Goiter in the Americas, in New Zealand and in England, Bull. History of Med. **17**: 229 (March) 1945.

MOTOR DRIVING AND EPILEPSY

In an attempt to clarify the status of the epileptic as motor vehicle drivers and to provide a basis for state laws and regulations for these drivers, Glaser and Irons [1] sent a detailed questionnaire to 127 members of the International League Against Epilepsy. On the basis of the answers received it is recommended that "epilepsy or other conditions causing lapse of consciousness with loss of motor or sensory control should be made reportable." (In California epilepsy is reportable to the State Department of Public Health and the State Department of Motor Vehicles.) State legislation should be enacted which prevents persons with epilepsy from driving motor vehicles unless free from seizures for a three year period. Nocturnal seizures or an aura should not be considered safety factors. Persons with secondary epilepsy or other syndromes with lapse of consciousness should not be permitted to drive. Licenses may be issued to them or restored at an earlier period when the seizures are under medical control. A diagnosis of epilepsy should be made on a clinical basis with the electroencephalogram used only to supplement the clinical diagnosis.

1. Glaser, Mark Albert, and Irons, Martin: Is the Epileptic a Safe Motor Vehicle Driver? J. Nerv. & Ment. Dis. **103**: 21 (Jan.) 1946.

MEDICINE AND THE WAR

ARMY

HISTORY OF MEDICAL DEPARTMENT IN WORLD WAR II

An Advisory Editorial Board on the History of the Medical Department in World War II was recently established in the Office of the Surgeon General. The board will advise and assist the Surgeon General in the formulation of overall plans and policies relative to the preparation and publication of the medical portion of the War Department History of World War II. It will be concerned primarily with the organizational aspects of the history and the method of presenting historical material covering the operational and clinical experience of the Medical Department in all major commands of the Army.

The following have been appointed members of the Advisory Editorial Board:

Col. Albert G. Love, M. C. (retired), chairman.
Major Gen. Paul R. Hawley, U. S. Army (retired).
Brig. Gen. Raymond A. Kelser, U. S. Army (retired).
Brig. Gen. Raymond W. Bliss, U. S. Army.
Brig. Gen. Malcolm Grow, U. S. Army.
Brig. Gen. Stanhope Bayne-Jones, U. S. Army.
Col. Paul I. Robinson, M. C.
Col. Michael E. DeBakey, M. C.
Lewis H. Weed, M.D.
Morris Fishbein, M.D.
J. Ben Robinson, D.D.S.
Richard H. Shyrock, Ph.D.
Major John J. Lentz, M.A.C., recorder (without vote).

"THE WELCH STORY" ON EXHIBIT

"The Welch Story," a pictorial history of the establishment and operation of Welch Convalescent Hospital, Daytona Beach, Fla., is on exhibit in Hospital and Domestic Operations Division, Office of the Surgeon General, in room 2E528, the Pentagon.

The idea of such an illustrated record was first conceived by members of the Hospital and Domestic Operations Division, who found that neither the Library of Congress nor the National Archives has any comprehensive material on convalescent hospitals of past wars. Through their efforts, in collaboration with the patients and the hospital staff of Welch Convalescent Hospital, "The Welch Story" was written, illustrated and bound.

In addition to the copy on display there, one will be placed in the Library of Congress as a permanent record and another will be furnished the Brooke Army Medical Center, Fort Sam Houston, Texas, for use as an instruction aid.

ARMY AWARDS AND COMMENDATIONS

Colonel E. R. Long

Col. E. R. Long, chief consultant in tuberculosis, Office of the Surgeon General, was recently awarded the Legion of Merit for his work in the "initiation and development of standards and measures for the detection of tuberculosis." Colonel Long's distinguished service in also establishing "priceless permanent files of chest x-ray films of army personnel," together with his methods of tuberculosis detection, was "of outstanding and lasting significance to the public health program of the country." Prior to entering the Army, Colonel Long was director of the Henry Phipps Institute and professor of pathology at the University of Pennsylvania School of Medicine. He graduated from Rush Medical College, Chicago, in 1925 and was commissioned in the Army in July 1942.

Major Milton Friedman

The Legion of Merit was recently awarded to Major Milton Friedman at the Army Medical Center, Washington, D. C. The citation which accompanied the award stated that Major Friedman, during his service as chief of the Radiation Therapy Section at Walter Reed General Hospital from May 1942 to January 1946, had "invented many new and improved instruments and technics for the treatment of malignant growths." The citation commended Major Friedman for "his services rendered with unselfish devotion to the welfare of the sick and wounded" and ended with the statement that his service rendered would be "of lasting benefit to mankind." Dr. Friedman graduated from George Washington University School of Medicine in 1926 and entered the service May 10, 1942.

Captain T. Philip Dann

Capt. T. Philip Dann, St. Petersburg, Fla., was recently awarded the Bronze Star "for distinctive heroism in connection with military operations against the enemy on March 23, 1945 near Dexhein, Germany. While supporting the crossing of the Rhine River at Dexhein, the aid station was subjected to enemy bombing, strafing and artillery fire. Despite imminent danger and with complete disregard for personal safety, Captain Dann, a station platoon leader, rendered medical assistance to the wounded and carried those without shelter to places of safety during the height of the attack. He alleviated their suffering and arranged for speedy evacuation of all wounded men. His heroic action and devotion to duty aided immeasurably in the saving of many lives and reflect great credit on himself and the Medical Department." Dr. Dann graduated from Louisiana State University College of Medicine in 1943 and entered the service Jan. 4, 1944.

Colonel Edward D. Churchill

Col. Edward D. Churchill, Boston, who was responsible for the introduction of reparative surgery in the base hospitals of the Mediterranean Theater of Operations during the war, was recently presented with the Distinguished Service Medal. Dr. Churchill is also the recipient of the Legion of Merit (THE JOURNAL, Aug. 18, 1945, p. 1170). He graduated from Harvard Medical School, Boston, in 1920 and entered the service Jan. 10, 1943.

Lieutenant Colonel Roderick G. St. Pierre

The Bronze Star was recently presented to Lieut. Col. Roderick G. St. Pierre, Portland, Ore., "for meritorious services as a member of the Advance Section Communications Zone, work which contributed materially to and was beneficial to our cause." Dr. St. Pierre graduated from Georgetown University School of Medicine, Washington, in 1933 and entered the service Oct. 10, 1941.

Colonel John C. Burch

The Legion of Merit was recently awarded to Col. John C. Burch, Nashville, Tenn. Dr. Burch was chief of surgical service, Burke General and Convalescent Hospital, Fort Sam Houston, Texas, from August 1942 to July 1945. Dr. Burch graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1923 and entered the service Aug. 24, 1942.

Lieutenant Arthur L. Rich

The Bronze Star was recently awarded posthumously to Lieut. Arthur L. Rich, Brooklyn, "for heroic action in connection with military operations against the enemy from Feb. 28, 1945 to March 6, 1945 in Germany." Dr. Rich graduated from the Long Island College of Medicine, New York, in 1939 and entered the service March 24, 1942.

Captain Nicholas A. Novalis

Capt. Nicholas A. Novalis, Long Island City, N. Y., was recently awarded the Bronze Star "for heroic action in the D day invasion." Dr. Novalis graduated from the New York Medical College, Flower and Fifth Avenue Hospitals, in 1937 and entered the service Jan. 28, 1941.

PUBLIC HEALTH SERVICE

INSTRUCTIONS FOR PUBLIC HEALTH CLAIMANTS

Instructions to eligible public health claimants for purchasing surplus property at a 40 per cent discount were recently made available by the U. S. Public Health Service, Robert C. Ayers, director, War Property Distribution, Federal Security Agency, announced. A 40 per cent discount from "fair value" will be granted eligible public health claimants under regulation 14 issued by the former Surplus Property Administration. Included among eligible claimant groups are state, county and local official public health agencies, such as health and sanitation departments, water works, sewerage systems and garbage and disposal plants. Also entitled to the discount are hospitals operated by nonfederal governmental agencies, nonprofit hospitals, clinics and public health research organizations, schools of nursing medicine, dentistry, public health and pharmacy, and certain miscellaneous nonprofit groups organized primarily to promote the public health.

To qualify for a price discount, a public health institution or instrumentality must be either an instrumentality of a state or a local government or tax exempt under section 101 (6) of the Internal Revenue Code and organized primarily for promotion of public health. It must also show that the property is for its own use to fill a legitimate need and will be used to promote the public health, and its application must be approved by a Public Health Service representative. Applicants in doubt of their eligibility should consult the nearest Public Health Service representative, Office of Surplus Property Utilization, whose address is listed in the instructions.

Inquiries concerning availability of surplus foods should be directed to the United States Department of Agriculture, Production and Marketing Administration, attention Surplus Property, Washington 25, D. C.

Copies of the instructions may be obtained from the Office of Surplus Utilization, U. S. Public Health Service, Railroad Retirement Building, Washington 25, D. C., and from the U. S. P. H. S. representative in the War Assets Corporation regional consumer goods office.

APPOINTED HEAD OF DIVISION OF NURSING

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, recently announced the appointment of Miss Lucile Petry, head of the U. S. Cadet Nurse Corps, as chief of the new Division of Nursing. Miss Petry was one of the first nurses to be commissioned in the Regular Corps of the Public Health Service. Her rank while serving as chief of a division is Nurse Director. Miss Petry will advise the Surgeon General regarding plans, programs and policies for the service in relation to nursing activities. Among these are the recruitment and training of graduate nurses, standards for nursing practices and personnel, and projects for studies of and research in nursing and those involving nursing.

MISCELLANEOUS

MEDALS OF MERIT AWARDED TO THREE PHYSICIANS

Drs. Francis Gilman Blake, president of the Army Epidemiological Board, Alfred Newton Richards, chairman of the Committee on Medical Research, Office of Scientific Research and Development, from July 16, 1941 to Sept. 2, 1945, and Lewis H. Weed, chairman of the Division of Medical Sciences, National Research Council, were recently awarded Medals for Merit by Major Gen. Norman T. Kirk, which were personally signed by President Truman.

Dr. Blake, dean of Yale University School of Medicine, New Haven, Conn., has been assisting the Army since 1940. For a time he served as director of a special commission which the Surgeon General and the United States of America Typhus Commission sent to New Guinea to investigate scrub typhus fever. The citation accompanying the award was addressed to "Francis Gilman Blake, A.B., M.A., M.D., Sc.D., eminent physician and scientific investigator, leader in curative and preventive medicine, wise and able administrator, devoted servant of health of the armed forces" and he was cited "for exceptionally meritorious conduct in the performance of outstanding services as consultant to the Secretary of War and president of the Army Epidemiological Board. Through his organization and direction of the Army Epidemiological Board since its establishment by the Secretary of War in January 1941, Dr. Blake has guided investigations, policies and measures which have safeguarded the health of troops. He has directed research and the applications of research which have resulted in decrease of infectious diseases at army posts and stations in this country and overseas and which have led to development of new protective measures. He has administered the Army Epidemiological Board as a means for preparation in advance of the outbreak of the war and as an effective weapon to combat communicable diseases during the war. In addition to his constant advisory assistance and supervision of the activities of the ten commissions under the Army Epidemiological Board he has contributed benefits by his own personal participation in field work, under campaign conditions, to the understanding and control of scrub typhus fever, one of the most serious hazards to the health of troops in the Southwest Pacific Area. In his capacity as trusted adviser on the health of the Army and as leader in investigation and control of influenza and other epidemic diseases in the Army, Dr. Blake has rendered courageous and exceptionally meritorious service to the nation."

In 1941 Dr. Richards, vice president in charge of medical affairs and professor of pharmacology at the University of Pennsylvania, was appointed chairman of the Committee on Medical Research. Since that time he has directed the committee's activities toward solving important medical problems embracing all phases of preventive and therapeutic medicine. His citation was "for exceptionally meritorious conduct in the performance of outstanding services to his country. Dr. Richards was directly responsible for organizing the program of research in military medicine. He initiated and supervised scientific research in the broad field of medical problems relating to the preparation for the war and for its conduct, and mobilized scientific personnel in specialized fields for intensive research for the Army and the Navy. Under Dr. Richards' inspiring leadership the program for the critical testing and mass production of penicillin was brought to a successful conclusion. The result was a material reduction in the pain, suffering and death necessarily incident to a prolonged war. Dr. Richards' vision and foresight were responsible for the organization of the most comprehensive attack on malaria which the world has ever seen. The astonishing accomplishments of this program played a substantial and often a decisive part in the victories of our armed forces. Both from a strategic and a humanitarian standpoint Dr. Richards' wartime contribution to his country has been of tremendous importance."

Dr. Weed, director of the Johns Hopkins University School of Medicine, Baltimore, and professor of anatomy at that school, has served as chairman of the Division of Medical Sciences, National Research Council, since 1939. Currently he is also serving as chairman of the National Advisory Committee of the American Red Cross. The citation, in which Dr. Weed was hailed as "eminent scientist and medical administrator," specified his "exceptionally meritorious conduct in the performance of outstanding services" and explained that "by his vision and energetic action Dr. Weed has rendered invaluable service to his country in the mobilization of eminent civilian specialists and through the stimulation and support of scientific projects which to so large an extent formed the basis of effective measures for the prevention and cure of diseases and battle injuries among the armed forces of the United States."

PHYSICIANS SEPARATED FROM SERVICE

ARMY MEDICAL CORPS OFFICERS RECOMMENDED FOR/OR RELIEVED FROM ACTIVE DUTY

California

Church, Claude H., Lt. Col., 1191 Spruce St., Berkeley.
Cook, Orrin S., Lt. Col., 1127 11th St., Sacramento.
Crockett, Herbert G., Major, 3531 Griffith Pk., Los Angeles.
Crump, John H., Capt., 1848 E. 15th St., Long Beach.
Davis, Andrew S., Capt., 3022 E. 14th St., Oakland.
Day, Boston M., Major, 450 Sutter St., San Francisco.
De Busk, Fred G., Lt. Col., 1600 Beverly Dr., Visalia.
Freidin, Morris, Capt., 1865 W. 39th St., Los Angeles.
Gallup, Charles A., Capt., 1930 Wilshire Blvd., Los Angeles.
Gianelli, V. J., Lt. Col., % J. B. Gianelli, 22 S. Center, Stockton.
Goerke, Lenor S., Major, 44 Pershing Ave., Woodland.
Gold, Rubin L., Major, 1559 Francisco St., San Francisco.
Goldstein, Louis B., Major, 758 33rd Ave., San Francisco.
Gusinow, Nathan R., Capt., 6227 W. Lindenhurst, Los Angeles.
Hall, Halle O., Capt., U. S. Vet. Hosp., W. Los Angeles.
Halter, Bert L., Major, 3878 Clay St., San Francisco.
Hamlin, John W., Capt., Tahoe City.
Hanna, Curtis M., Lt. Col., 3160 Palm St., San Diego.
Hanna, Ralph, Capt., 6671 Drexel Ave., Los Angeles.
Hickey, Norman G., Major, 2904 Live Oak St., Huntington Pk.
Hogue, William J., Major, 2669 Walnut St., Huntington Park.
Jones, Richard P., Capt., 541 42nd St., Sacramento.
Kansora, C. P., Capt., 1481 Plymouth Ave., San Francisco.
Kennedy, Charles R., Major, 1233 Olive St., Paso Robles.
Kilgore, George L., Major, 2478 Rosecrans St., San Diego.
Kobayashi, Norman T., Capt., 16212 Orchard Ave., Gardena.
Lawrence, Herbert, 1st Lt., 822 Pacheco St., San Francisco.
Leeds, Sanford E., Lt. Col., 325 15th Ave., San Francisco.
(Name changed from: Levy, Sanford Edgar.)
Levitin, Joseph, Lt. Col., 516 Sutter St., San Francisco.
Merrill, Lea W. Jr., Capt., 929 Colusa Ave., Berkeley.
Rand, Fredrick S., Major, 1578 E. Chevy Chase St., Glendale.
Roberts, Paul C., Capt., 244 K St., Eureka.
Rosen, Morris S., Capt., 1740 Broadway, San Francisco.
Ruden, Simon J., Capt., 313 F St., Eureka.
Soforenko, Harry, Major, 224 N. Kenmore, Los Angeles.
Stehly, Charles C., Capt., 156 S. Meredith Ave., Pasadena.
Tucker, Hyman, Major, Agnew State Hospital, Agnew.
Weks, Carrol L., Capt., 1057 Queen Anne Pl., Los Angeles.
Wilson, Ira H., Capt., 111 N. Freeman, Oceanside.
Wolfsen, Homer R., Capt., 5868 Picardy Dr., Oakland.

Illinois

Bell., Donald I., Capt., Evanston Hosp. Assoc., Evanston.
Berard, LeRoy H., Capt., 1050 N. Hayes Ave., Oak Park.
Berman, Benjamin B., Capt., 1303 St. Louis Ave., East St. Louis.
Bianco, Peter B., Major, 400 W. 16th St., Chicago.
Boylston, George A., Major, 220 Broadway, Wilmette.
Britton, James H., Capt., 1957 23d St., Moline.
Brosnan, John J., Capt., 2002 W. 69th Pl., Chicago.
Brown, Cecil D., Major, 923 Monroe Ave., River Forest.
Brown, Wendell W., Major, 317 W. Main St., Collinsville.
Buckley, Joseph H., Capt., 3713 Wabansia Ave., Chicago.
Burroughs, Oscar J., Capt., 922 W. Eastwood Ave., Chicago.
Cervera, Dominic L., Capt., 3440 W. Franklin Blvd., Chicago.
Cesare, Antonio G., Major, 11051 S. Ave. J., Chicago.
Conti, James G. Jr., Lt. Col., 124 N. Parkside Ave., Chicago.
Cox, Elwood H., Capt., Mount Pulaski.
Crabtree, Joseph P., Major, 402 S. Yale Ave., Villa Park.
Cross, Roland R. Jr., Capt., Dahlgren.
Cumming, Thomas St., Major, Gardner.
Day, Robert F., Capt., 13301 Brandon Ave., Chicago.
Dillman, Howard B., Major, Flora.
Doktorsky, Abraham I., Capt., 1200 N. Ashland Ave., Chicago.
Firfer, Bourke, 1st Lt., 7458 Kingston Ave., Chicago.
Gannon, Paul A., Capt., 420 N. Chicago St., Pontiac.
Gilfillian, Homer John Jr., 1st Lt., 1629 Hampshire, Quincy.
Gish, Rutledge E., Major, 2001 Forest Ave., Eldorado.
Golden, Maurice J., Major, 3460 Lawrence Ave., Chicago.
Green, Alan D., Capt., 6823 N. Greenview Ave., Chicago.
Grotjahn, Martin, Capt., 5429 East View Park, Chicago.
Hall, Carl B., Major, 809 Central, Wilmette.
Kapov, Kozme F., Capt., 6613 Normal Blvd., Chicago.
Kenward, Roy L., Capt., Melvin.
Ketterer, Francis H., Major, Breese.
Kieffer, John P., Capt., 1505 Arthur Ave., Chicago.
Kleinman, Samuel B., Major, Chicago.
Kobrin, Meyer W., Capt., 1506 S. Keeler Ave., Chicago.
Korey, Herman G., Capt., 5465 S. Everett, Chicago.
Koucky, John D., Lt. Col., 1106 Keystone Ave., River Forest.
Milroy, Robert A. Jr., Capt., 300 S. 4th St., Aurora.

Illinois—Continued

Mooney, Felix P., Capt., 510 N. Goodwin Ave., Urbana.
Morris, Donald P., Major, 534 Linn St., Peoria.
Padorr, David, Capt., 1037 North Shore, Chicago.
Patchen, Paul J., Capt., 2536 E. 73rd St., Chicago.
Paull, Murry M., Capt., 1128 Hyde Park Blvd., Chicago.
Rosenthal, Carl, Major, 4417 N. Lawndale, Chicago.
Serritella, Rocco V., Capt., 1012 S. Ashland Blvd., Chicago.
Skeele, William A., Capt., 2120 Main St., Alton.
Skowron, John J., Capt., 5735 Wilson Ave., Chicago.
Van Kirk, Frank W. Jr., Capt., 105 E. Delaware Pl., Chicago.
Walzer, Israel, 1st Lt., 1835 W. Harrison St., Chicago.
Watters, Charles L., Capt., 217 S. State St., Geneseo.
Wendorf, Albert, Capt., 2008 Humboldt Blvd., Chicago.
Worsley, Hugh H., Capt., 6066 Forest Glen, Chicago.
Yonker, William, Major, 8945 S. Oakley Ave., Chicago.

New Jersey

Butenas, Joseph J., Capt., 300 1st Ave., Elizabeth.
Chesnick, Reuben B., Capt., 135 Woodland Ter., Oaklyn Manor.
Chodosh, Maurice A., Capt., 606 Roosevelt Ave., Carteret.
Close, Byron H., Capt., Main St., Bloomingdale.
Cohen, Samuel A., Major, 477 Jersey Ave., Jersey City.
Cornish, Charles H., Major, 673 Prospect St., Maplewood.
Di Nicolantonio, V. J., Capt., 3121 Atlantic Ave., Atlantic City.
Epstein, William M., Capt., Hotel Suburban, East Orange.
Farber, Herbert R., Capt., 178 Lawrence Pl., Paterson.
Friedenberg, Sidney, Capt., 2990 Alabama Rd., Camden.
Haines, Emerson S., Capt., 500 Eight Ave., Asbury Park.
Harris, Sidney, Capt., 420 E. 7th Ave., Roselle.
Hersohn, W. W., Major, 114 S. Illinois Ave., Atlantic City.
Holmes, Joseph H., Capt., 224 Hickory Ave., Tenafly.
Horowitz, Herman J., Lt. Col., 872 Broad Ave., Ridgefield.
Kuite, George B., Major, 435 Speedwell Ave., Morris Plains.
Lance, Elton W., Lt. Col., 125 W. Milton Ave., Rahway.
Liddy, Frank J., Major, Mahwah.
Luippold, Eugene J. Jr., Capt., 130 Fairview Ave., Boonton.
Lustig, Melvin, Capt., 349 Fabyan Pl., Newark.
McLane, A. D., Lt. Col., 498 Engle, Englewood.
Mancene, Edward M., Capt., 145 Marshall Ave., Little Ferry.
Schram, William S., Capt., 252 Bergen Ave., Kearny.
Scott, John J., Major, 6 Zorman Pl., Weehawken.
Sedgwick, Cornelius E., 1st Lt., 113 Union Rd., Roselle Park.

New York

Bass, Louis, Capt., 347 E. 173d St., New York.
Baudo, Salvator J., Capt., 21-44 41st St., Long Island City.
Becker, Benjamin J., Capt., 9349 212th Pl., Queens Village.
Belgorod, Samuel H., Major, 55 W. 11th St., New York.
Benson, Murray, Major, 721 Walton Ave., New York.
Berens, Abraham, Capt., 263 Eastern Parkway, Brooklyn.
Bogart, Harry, Major, 825 West End Ave., New York.
Bressler, Sydney, Lt. Col., 139 W. 82d St., New York.
Brown, Chester R., Major, 4418 Waldo Ave., New York.
Buchwald, Merwin E., 1st Lt., 1921 Ocean Ave., Brooklyn.
Buckbee, Harold Frederick, Capt., 15 Helmer Ave., Dolgeville.
Clyne, Robert M., 1st Lt., 1470 Taylor Ave., Bronx.
Codik, John G., Major, 464 E. 159th St., New York.
Cohen, Abraham G., Lt. Col., 9 E. 96th St., New York.
Constantino, Joseph G., Major, Ozone Park.
Coriale, Arthur S., Capt., 1021 Conkling Ave., Utica.
Davison, Selvan, Capt., 5 E. 101st St., New York.
De Marco, Mario M., Major, 3389 Sedgwick Ave., New York.
Demo, Robert A., Capt., 66 Willmont St., Rochester.
Dennis, Robert W., Major, 438 N. Main St., Herkimer.
Ettman, Irving K., Major, 1421 Vyse Ave., New York.
Feinberg, Harry, Capt., 634 Miller Ave., Brooklyn.
Fineberg, Seymour K., Capt., 1139 Nelson Ave., Bronx.
Fishberg, Archibald, Capt., 851 Manida St., Bronx.
Fox, Mark E., Capt., 129 MacDougal St., New York.
Frank, Lawrence, Capt., 1178 E. 9th St., Brooklyn.
Frazell, Edgar L., Capt., 121 E. 60th St., New York.
Friedenson, Meyer, Capt., 711 Walton Ave., Bronx.
Friedman, Herbert S., Major, 676 Riverside Dr., New York.
Gershberg, Herbert, Capt., 1160 Cromwell Ave., Bronx.
Gian, Mario C., Capt., 610 Niagara St., Buffalo.
(Name changed from: Gian-Franceschi, Mario Carle.)
Gianquinto, William M., Capt., 931 Kent Ave., Brooklyn.
Glenn, Frank, Lt. Col., 329 E. 68th St., New York.
Goldstein, Lester B., 1st Lt., 70 Rockaway Pkwy., Brooklyn.
Goodfriend, Murray I., 1st Lt., 500 Montgomery St., Brooklyn.
Gordon, George B., Capt., 1675 E. 18th St., Brooklyn.

PHYSICIANS SEPARATED FROM SERVICE

New York—Continued

Gould, Adrian G., Col., 12 Irving Pl., Ithaca.
Greene, David G., Capt., 42 Ashland Ave., Buffalo.
Greenwald, Murray, Capt., 1715 Bath Ave., Brooklyn.
Gregg, Robert O., Major, 303 Parsons Dr., Syracuse.
Hallemann, George, Capt., 122 Park Ave., Mt. Vernon.
Hallinger, Earl S. Jr., Lt. Col., 134 Washington Ave., Endicott.
Head, Arthur E., Major, 153 E. Main St., Gouverneur.
Heldman, Arthur, Major, 2876 Jerome Ave., Bronx.
Helman, Charles H., Major, 735 Mace Ave., Bronx.
Israel, Benjamin, Capt., 1895 Morris Ave., Bronx.
Jones, Augustin, Capt., 28-55 216th St., Bayside.
Josephson, Frederick, Major, 142-05 60th Ave., Flushing.
Juster, Irving R., Lt. Col., 105 Ridge St., Glens Falls.
Kammerer, William H., Major, Whitestone, Queens.
Kaplan, L., 1st Lt., 1910 Foster Ave., Brooklyn.
Karpenski, Stephen J., Lt. Col., 132 No. St., Auburn.
Kempfner, Joseph, Major, 120 E. 85th St., New York.
Kempner, William J., Capt., 99-08 67th Ave., Forest Hills.
(Name changed from: Kempner, Mortimer Jay.)
Kera, Henry M., Major, 17 Park Ave., New York.
Kerr, George K., Capt., 239 Herberton Ave., Port Richmond.
Kidder, Russell S. Jr., Major, 36 Kenova Pl., Buffalo.
Levine, Bernard R., Capt., 1342 Findlay Ave., Bronx.
Levine, Samuel N., Capt., 501 Euclid Ave., Elmira.
Levy, Edward, Capt., 235 E. 22nd St., New York.
Levy, Hyman, Capt., 230 Riverside Dr., New York.
Lieberman, David, Capt., 152 S. 9th St., Brooklyn.
Lipschitz, Samuel, Capt., 723-7 E. 182nd St., Bronx.
Lucas, Alphonse F., 1st Lt., 45 Oak St., Hornell.
Lynch, William G., Capt., 6843 Central Ave., Glendale.
Lyon, Ernst F., Capt., 117-01 Park Lane, S., Kew Gardens
McGuigan, Leonard M., Capt., 126 Division St., Amsterdam.
Melfi, Domenick J., Capt., 2235 Tiemann Ave., Bronx.
Mintz, Bernard J., Lt. Col., 170 W. 77th St., New York.
Miscall, Laurence, Lt. Col., 5 Russel Pl., Forest Hills.
Molinoff, David D., Major, Smithtown Branch, L. I.
Montag, Leonard, Capt., 68-63 108 St. Forest Hills.
Moore, James A., Capt., 490 Western Ave., Albany.
Rosenthal, R. L., Capt., Willard Parker Hosp., New York.
Rudin, Louis N., Capt., Welfare Hosp., Welfare Island.
Ryan, Jeremiah E., Capt., Bellevue Hospital, New York.
Saltz, Herman P., Capt., 45 Sammis Ave., Huntington.
Sanfilippo, Paul J., Major, 25-50 Gilmore St., East Elmhurst.
Scacciaferro, Anthony W., Capt., 4016 9th Ave., Brooklyn.
Schultz, Jacob P., Major, 843 E. 10th St., Brooklyn.
Schwartz, Ralph, 1st Lt., 101 East 169th St., New York.
Slater, Max, Major, 4115 45th St., Long Island City.
Smedal, Sigmund H., Capt., 385 Morris St., Albany.
Smith, John J., Major, 525 E. 68th St., New York.
Sordillo, Sabato-Vincent R., Capt., 1221 York Ave., New York.
Steinhausen, Theodore B., Capt., 60 Cathaway Pk., Rochester.
Stella, Mario E., Capt., 303 West 91st St., New York.
Storch, Sidney, Capt., 645 Ocean Parkway, Brooklyn.
Zukauckas, E. W., Lt. Col., 4302 Flatlands Ave., Brooklyn.

Ohio

Blackburn, John H., Capt., 1896 N. 4th St., Columbus.
Bowman, Harold J., Major, 1604 27th St. N. W., Canton.
Bowsher, Robert E., Major, 4505 River Road, Toledo.
Brown, John Q., Capt., 2941 Crescent Dr., Columbus.
Burroughs, Shepard A., Capt., 4500 Park Ave., Ashtabula.
Campbell, Rundle D., Capt., 191 Helen Ave., Mansfield.
Chaikin, William E., Capt., 2010 E. 102d, Cleveland.
Dickey, L. C., Capt., 3093 Huntington Rd., Shaker Heights.
Donnelly, James H. Jr., Capt., University Hosp., Cleveland.
Drake, John C., Lt. Col., Edgewood Rd., Mt. Vernon.
Edwards, Walter V. Jr., Capt., 812 Michigan, Youngstown.
Elliott, William E., Major, 217 Simpson St., Alliance.
Forrester, Joseph C., Major, 511 Fairwood Ave., Columbus.
Franke, William J., Capt., 900 Peerless Ave., Akron.
Friedman, Leo S., Major, 3854 Spring-house Lane, Cincinnati.
Giber, Philip B., Major, 4 N. State St., Girard.
Harper, E. O'N., Lt. Col., 16185 Cleviden Rd. E., Cleveland.
Hauser, Willard E., Capt., 4218 Rocky River Dr., Cleveland.
Heller, Morris I., Capt., 10113 Pierpont Ave., Cleveland.
Howe, Charles E., Lt. Col., Westerville.
Jacob, John, Capt., 3029 Ludlow Rd., Shaker Heights.
Kaval, Vincent T., Capt., 12805 Shaker Blvd., Cleveland.
Keiser, Harold LeR., Capt., 906 W. State St., Fremont.
Kingsley, Glenn E., Major, 1160 8th St., Lorain.
Klinge, John E., Capt., 910 Main Ave., W., Massillon.
Krichbaum, William T., Capt., 214 E. Maple St., North Canton.
Kriz, Joseph R., Lt. Col., Lucas County Hospital, Toledo.

Ohio—Continued

Krupko, Paul E., Capt., 3590 Farland Rd., Cleveland Heights.
Lamkin, Glenn S., Capt., Sardinia.
Leviticus, Rene, Capt., 2242 E. Market St., Warren.
Leyrer, Ralph H., Major, 803 Franklin St., Hamilton.
Lombardi, Louis F., Capt., 249 Crosby St., Akron.
Mollin, Edwin L., Capt., 175 Merriman Rd., Akron.
Piver, William C. Jr., Capt., 1818 Farmington, East Cleveland.
Rhiel, James I., Capt., 215 W. High St., Eaton.
Roden, Carl A., Capt., 450 S. 2nd St., Hamilton.
Schnitker, Max T., Lt. Col., 2547 Cheltenham Rd., Toledo.
Searle, Clark P., Capt., 225 Charles St., Wyoming.
Smith, John J., Capt., 1842 Caldwell Ave., Cleveland Heights.
Terrell, Virgil E., Capt., 1360 Giel Ave., Lakewood.
Tichy, Vladimir L., Major, 3515 W. 98th St., Cleveland.
Walzer, Leo, Major, 3166 Redwood Rd., Cleveland.

Pennsylvania

Bantly, Harry C., Capt., Imperial Hotel, Reynoldsville.
Beatty, W. A. Jr., Capt., 336 Ave F, Forest Hills, Pittsburgh.
Blaker, Martin A., Capt., 765 S. 5th St., Philadelphia.
Bolich, John A., Major, 717 N. Front St., Milton.
Boyle, Bruce C., Capt., 223 Marguerite Ave., Wilmerding.
Bremer, Harry J., Capt., 246 Greeve St., Conemaugh.
Chachkin, Samuel, Capt., 5017 N. 10th St., Philadelphia.
Chasler, Charles, Capt., 402 Sampson St. N.W., Pittsburgh.
(Changed from Ciaccia, Charles N.)
Cohen, Samuel F., Capt., 1217 Dekalb, Norristown.
Craighill, Margaret D., Lt. Col., Woman's Med. Col. of Pa., Philadelphia.
Faries, George B., Major, 7806 Cresheim Rd., Philadelphia.
Feltwell, Peter M. Jr., Capt., 227 Beaver St., Sewickley.
Gerwig, Theodore C. Jr., Capt., 1504 Murray Ave., Pittsburgh.
Gibson, William B., Lt. Col., 40 Drexel Ave., Lansdowne.
Goldberg, Solomon, Major, 2730 Broadway, Pittsburgh.
Greenspon, Samuel E., 1st Lt., 2078 Wilmot St., Philadelphia.
Harmeier, John W., Lt. Col., 121 University Pl., Pittsburgh.
Harwick, Ralph F., Capt., 102 N. 13th St., Allentown.
Hays, Clinton A., Major, 232 E. 6th St., Oil City.
Heintzelman, George W., Major, Neffs, Lehigh Co.
Hibbs, John B., Capt., 51 W. Fayette St., Uniontown.
Hoch, Vincent A., Capt., 145 Oak St., Butler.
Hubbard, Charles C., Col., 150 Stockton Ave., Uniontown.
Johnson, Julian, Major, 3400 Spruce St., Philadelphia.
Johnson, Leonard Z., Capt., 1528 N. 6th St., Harrisburg.
Kalstone, Bernard M., Capt., 1326 Bailey Ave., McKeesport.
Kaplan, Albert J., Major, 6103 N. 17th St., Philadelphia.
Karmilowicz, Norman A., Capt., 792 Market, Kingston.
Katzen, Raymond, Capt., 6000 M 20th St., Philadelphia.
Kaufman, Sidney S., Capt., 6386 Ebdy St., Pittsburgh.
Keller, Earl B. Jr., Capt., 323 Midland Ave., Wayne.
Kessler, Carl C., 1st Lt., 1014 Meade St., Reading.
Kincov, Jacob, Major, 512 Cattell St., Easton.
Kirk, Milo M., Capt., 2307 Brownsville Rd., Pittsburgh.
Kleinguenther, C. J., 1st Lt., 2100 W. Cheltenham, Philadelphia.
Levan, John B., Lt. Col., 401 Oley St., Reading.
Levin, Herman H., Major, 207 E. Boyles Ave., New Castle.
Lewine, Yale S., Capt., Jefferson St., Beaverdale.
Libener, Otto J., Capt., 79 N. Vine St., Hazleton.
Lombardi, Salvatore L., Capt., 5438 Wayne Ave., Philadelphia.
Lutton, Edward C., Lt. Col., 306 W. Pearl St., Butler.
Yakulis, C. W. Jr., Capt., 340 McKinley, East Vandergrift.

Rhode Island

Berrillo, Anacleto, Capt., 53 Grove St., Providence.
Flynn, Joseph C., Capt., 559 Cranston St., Providence.
Hayes, Walter E., Capt., 1103 Cranston St., Cranston.
Hecker, Harry, Capt., 445 Pawtucket Ave., Pawtucket.
Sherman, Bernard I., Major, 1022 Broad St., Providence.

South Carolina

Baroody, Albert J., 1st Lt., 105 Main St., Timmonsville.
Blake, Herbert, Capt., 204 Calhoun St., Anderson.
Coleman, Marshall J., Major, 120 Coshua St., Darlington.
Holmes, Gertrude R., Capt., 709 Arlington Ave., Greenville.
Jones, William B., Major, County Health Dept., Beaufort.
Kaufman, Samuel, Capt., York.
McCoy, Edwin R., Capt., Roper Hosp., Charleston.
McLain, William C. Jr., Capt., 1812 Seneca Ave., Columbia.
McNulty, Robert B., Major, 1633 Heyward St., Columbia.
Mayer, Orlando B., Lt. Col., 1527 Devenshire Dr., Columbia.

Wyoming

Rosene, William E., Capt., Wheatland.

MEDICAL OFFICERS RELEASED BY THE NAVY

NAVAL RESERVE MEDICAL OFFICERS RECOMMENDED FOR RELEASE FROM ACTIVE DUTY

Alabama

Kent, James M.....Birmingham
Kimbrough, Benjamin B. Jr.....Nanco
Stewart, Roddie L.....Birmingham

Arizona

Kimball, Albert P.....Yuma

Arkansas

Hebert, Gaston A.....Hot Springs

California

Bigler, Roscoe H.....Southgate
Brinckerhoff, Albert J.....San Francisco
Campion, George S.....San Francisco
Cosgrove, Clair P.....Los Angeles
Cover, William L.....San Bernardino
Crenshaw, Gerald L.....Oakland
Folkenberg, Alvin W.....Glendale
Forman, Joseph B.....Oakland
Goutiere, Vernon G. G....San Francisco
Griffith, Powell W.....Los Angeles
Gustin, James Wm., Jr...Newport Beach
Henderson, Ernest W.....Alameda
Henry, Merlyn G.....Los Angeles
Hidley, Herbert J.....Los Angeles
Hillyer, Edwin A.....Hayward
Johnson, Chester F.....Oakland
Johnson, James K.....Los Angeles
Kimball, David C.....Coronado
Kitchen, Burton E.....Salinas
Kraft, Rollan W.....Pasadena
Magoon, Leslie B.....San Jose
McCarthy, William D.....Oakland
Millar, Glenn E.....Sacramento
Muir, James C.....San Jose
Norwood, Jackson.....Pasadena
Novacovich, George G....San Francisco
O'Connor, Gerald B.....San Francisco
Perroden, Chester A.....Sherman Oaks
Poulsen, Theodore S.....San Francisco
Rogers, Wilbur G.....Los Angeles
Scheffel, Alfred G.....Los Angeles
Scoins, William H.....Altadena
Scott, Walter.....Glendale
Shelden, Charles H. Jr.....San Marino
Silvani, Henry L.....San Francisco
Silver, Bernard.....Los Angeles
Strang, Theodore A.....Long Beach
Thompson, Ferris W.....Monterey
Tyroler, Frederick N.....Los Angeles
Wagner, Robert L.....San Francisco
Williamson, William T.....Colton
Young, Thomas L.....Long Beach
Zealear, David S.....San Francisco

Colorado

Altmix, Richard H.....Denver
Dille, Frank McE.....Greeley
Evans, Albert E.....Denver
Hall, Richard H.....Denver
Hirst, William R.....Pueblo
Messenheimer, Myron G.....Denver

Connecticut

Backhus, Louis C.....Waterbury
Bausch, Carl P.....West Hartford
Carvey, Edward V.....Wethersfield
Guida, Francis P.....North Haven
Jackson, Albert L.....Waterford
James, Lewis P.....West Hartford
Keefe, Walter J.....Hartford
LaBrecque, Frederick C.....Waterbury
Lincourt, Armand S.....Thompsonville
McCrann, Donald J.....Bloomfield
Mignone, Joseph.....New Haven
Moore, Donald B.....New Haven
Murphy, Thomas D.....W. Hartford
O'Brien, Francis H.....New Britain
Peacock, Albert U.....West Hartford

Connecticut—Continued

Romaniello, Rosso J.....West Hartford
Seigle, Stewart P.....West Hartford
Taylor, Robert M.....East Haven
Watson, William J.....New Britain
White, John C.....New Britain

District of Columbia

Baxter, Marshall D.....Washington
Derzavis, Jack L.....Washington
Greenberg, Robert M.....Wash. D.C.

Florida

Fitzpatrick, Emmett T.....Miami Beach
Kenaston, Thomas C.....Cocoa
Lawther, Harry C.....Miami
Pearson, Rufus J., Jr.....Coral Gables
Robertson, James C.....Vero Beach
Stewart, Franz H.....Miami

Georgia

Dougherty, Mark S., Jr.....Atlanta
McGeachy, Thomas E.....Decatur
Stearns, Dana P.....Augusta
Victor, Jules Jr.....Savannah

Idaho

Annest, Leonidas.....Declo

Illinois

Anderson, Truman O.....Glenwood
Athey, George L.....Beardstown
Baugher, John O.....Chicago
Dorr, Edward M.....Chicago
Burge, Edward S.....Evanston
Egan, William B.....Chicago
Foltz, Herbert Leo.....Chicago
Greeley, Paul W.....Winnetka
Grissom, Raymond F.....Oak Park
Hammel, George W.....Chicago
Hansen, Stephen J.....Effingham
Hausman, Charles M.....Chicago
Hindman, Joseph F.....Urbana
Koscinski, Leon J.....Chicago
Kurth, Milton E.....Chicago
Milroy, John J.....North Chicago
Patton, Robert J.....Springfield
Ponzer, Ernest D.....Chicago
Quinn, Francis M.....Chicago
Rice, Herbert R.....Lake Forest
Sharp, Jack M.....Lake Forest
Slepyan, Albert H.....Park Ridge
Snively, William D., Jr.....Rock Island
Stack, Eugene A.....River Forest
Sternes, Frank C.....Chicago
Strauss, Hermand A.....Chicago
Thompson, Ivan.....Evanston
Varzino, Louis S.....Chicago
Waller, George H. Jr.....Maroa
Winters, Kenneth J.....Scales-Mound

Indiana

Bailey, Lawrence S.....Zionsville
Brenner, Andrew M.....Winchester
Hane, Richard L.....Fort Wayne
Leich, Charles F.....Evansville
Miller, William E.....South Bend
Pearce, Roy V.....Terre Haute
Stewart, Wayne H.....Kendallville

Iowa

Elmore, Ernest F.....Hartley
Goad, Robley R.....Muscatine
Hansen, Russell R.....Storm Lake
Hersey, Nelson L.....Independence
Irwin, Ralph L.....Iowa City
Kenefick, John N.....Algona
Laughlin, Ralph M.....Cedar Rapids
McGowan, James P.....Harlan
Powell, Robert A.....Farragut
Waggoner, Charles V. E.....Clinton
Webber, Richard J.....Fort Madison

Kansas

Eckart, DeMerle Emery.....Gardner
Moorman, Victor R.....Nickerson

Kentucky

Butler, Francis H.....Louisville
Crowder, Marion O.....Hartford
Shacklette, Cripps B.....Shively
Slucher, Richard R.....Buechel

Louisiana

Cain, Frank A.....Rayville
Frederick, Charles O.....Covington
Lally, John F., Jr.....New Orleans
Sonnier, Lee J.....Scott
Taylor, Phillip W.....New Orleans

Maine

Coffin, Ernest L.....Northeast Harbor
Hynes, Edward A.....So. Portland

Maryland

Darnall, William R.....Rockville
Geschickter, Charles F.....Baltimore
Jeppi, Joseph V.....Baltimore
Moore, Frank R.....Baltimore

Massachusetts

Arbetter, Joseph D.....Saugus
Altman, Isadore.....N. Attleboro
Benson, Harry L.....Winchester
Cassaday, Paul B.....Nantucket
Bryan, Charles S., Jr.....Cambridge
Donabedian, George.....Worcester
Dorman, Daniel B.....Cambridge
Drew, Roger T.....Lowell
Egan, John J. Jr.....Gloucester
Goodwin, Arthur H.....Everett
Hathaway, Louis E., Jr....Longmeadow
Heath, Wilmer P.....Needham
Heller, Hyman.....Webster
Herman, Herbert R.....Hingham
Higgins, Francis H.....Chestnut Hill
Hindman, Daniel H.....Laurence
Hopkins, Henry P.....Chatham
Lamb, Gordon R.....Boston
MacDonald, A. S. Jr.....Winchester
Marlin, Myer.....Cambridge
McCausland, William A.....Quincy
Miller, Donald G.....Everett
O'Day, John J.....Worcester
Reynolds, Edward J.....Malden
Stevenson, Charles S.....Pittsfield
Suitor, Douglas G.....Springfield
Tierney, Thomas M.....Boston

Michigan

Adler, Sidney.....Detroit
Baer, Louis S.....Ann Arbor
Davies, Windsor S.....Grosse Pte. Pk.
Jennings, Robert M.....Detroit
Lichter, Max L.....Detroit
Murphy, Francis J.....Detroit
Virga, George M.....Detroit

Minnesota

Anderson, Donald C.....St. Paul
Johanson, Waldemar G.....St. Paul
Larson, Lawrence M.....Minneapolis
Martin, Webster C.....Duluth
McKenzie, Charles H.....Minneapolis
Mead, Charles H.....Duluth
Merrill, Robert W.....Morris
Mork, Frank E.....Anoka
Schuele, David T.....Chatfield
Sloan, Benjamin C.....St. Paul
Smith, Graham G.....Fulda
Wilder, Thomas C.....Rochester

MEDICAL OFFICERS RELEASED BY THE NAVY

Missouri

Duncan, Ralph E.....Kansas City
Gilfillan, Earl E.....Memphis
Henrickson, Hardin O.....Poplar Bluff
McAlester, Andrew W., III.Kansas City
McPheeters, James W.....Poplar Bluff
Smit, Herbert M.....University City
Zuber, Harold V.....Kansas City

Nebraska

Bradley, James D.....Lincoln
Elliott, Clarence K.....Lincoln
Garlinghouse, Richard E.....Lincoln
Rosenau, John A.....Scottsbluff
Travnicek, Frank G.....Wilber

Nevada

Cantlon, Vernon.....Reno
Sylvain, Gerald J.....Las Vegas

New Hampshire

Doyle, Peter J.....Dover
Gray, Frederick S.....Portsmouth

New Jersey

Barlow, Frank A.....Paterson
Bigelow, Nelson S.....So. Orange
Boyle, Francis L.....Bayonne
Burbank, John H.....East Orange
Carpenter, Cedric C.....Summitt
Chmelnik, Abraham G.....Newark
Ciccone, Edwin L.....Newark
Fischman, Mervin.....Irvington
Fissell, George M.....Newark
Frank, Perry.....Egg Harbor
Goldfarb, Abraham.....Rutherford
Hasney, Frederick A.....West Orange
Mott, Joseph E.....Paterson
Murphy, Thomas W.....Short Hills
Palma, Nicholas.....Paterson
Schubert, Roy R.....No. Haledon
Swiney, Merrill A. III.....Bayonne
Tebrock, Harry E.....Atlantic City
Thomas, John H.....So. Orange
Van Gieson, Edward J.....Bloomfield
Walker, Nelson C.....Ridgewood

New Mexico

Griffin, John W. Jr.....Riverdale
Roberts, Bennett F.....Albuquerque

New York

Armstrong, John T.....New York
Babcock, Henry H.....New York
Babey, Andrew M.....Brooklyn
Bagg, James F.....Mt. Vernon
Barer, Charles G.....Bronxville
Block, Morris.....New York
Boggs, Edward H.....New York
Brown, Lewis W.....Woodmere
Brust, John C. M.....Syracuse
Bugbee, Lucius H. Jr.....Jamestown
Butler, Hugh H.....New York
Cushing, Robert M.....Brooklyn
De Pietro, Joseph.....New York
Doll, Leo Joseph L.....Buffalo
Dougherty, Thomas G.....New York
Dubois, John C.....New York
Eilert, John H.....New York
Gackenheimer, Charles D.....Jamaica
Glasser, Benjamin F.....Kew Gardens
Goldberg, Jacob.....Saranac Lake
Goldner, Abraham I.....Flushing
Haines, Henry H.....Rochester
Herman, John R.....New York
Higginson, John F.....Queens, L. I.
Hoffeld, George D.....New York
Hollander, Mark B.....New York
Hornstein, Samuel L.....Brooklyn
Hotchkiss, Robert S.....Forest Hills
Humphrey, Henry D.....Lowville
James, William E. S.....New York
Johnson, Porteous E.....Spencer
Koop, Robert F.....Peekskill
Kraimin, Philip.....New York

New York—Continued

Laughlin, Elmer H.....Brooklyn
Lautzenheiser, Ross B.....Penn Yan
Lewis, Leon.....New York
Lhamon, William T.....New York
Martorano, Gerard.....New York
Master, Arthur M.....New York
Morrissey, Vincent J.....New York
Osborne, John R.....Middletown
Patrick, Ralph C.....Brooklyn
Ridenour, John W. Jr.....White Plains
Rogoff, Jacob.....Brooklyn
Rosenberg, Julius.....Brooklyn
Sainsbury, Augustus W.....Canandaigua
Schwedel, John B.....New York
Snodgrass, John J.....New York
Southworth, Franklin C., Jr.....Buffalo
Star, Leon D.....Far Rockaway
Strange, Theodore B.....Albany
Stubenford, William D.....New York
Sulzman, John H.....Troy
Sussman, Leon N.....New York
Tesoriero, Vincent J.....Brooklyn
Thompson, Howard T.....Rochester
Young, George S.....Buffalo

North Carolina

Chambers, Paul J., Jr.....Charlotte
Goddard, David W.....Durham
Grady, Edgar D.....Wilson
Lounsbury, James B.....Wilmington
Morgan, Ralph S., Jr.....Chapel Hill
Norris, Charles B.....Charlotte
Powell, Thurston, G.....Wilminton
Wilson, James M.....Durham

North Dakota

Darner, Charles B.....Fargo

Ohio

Allen, Herbert V., Jr.....Cincinnati
Bennett, Alwyn E.....Cleveland
Bonnot, Bernard Robert.....Canton
Bossert, Lester J.....Cincinnati
Butcher, Wendell A.....Lancaster
Byrne, Thomas E.....Mentor
Cassidy, Robert H.....Columbus
Castle, Charles A.....Cincinnati
Clark, Willard C.....Dayton
Davis, Adrain E.....Akron
Fry, Francis O.....Cleveland
Funk, John A.....Coshocton
Gusman, Harry A.....Shaker Heights
Hart, Albert J.....Cleveland
Irving, Richard C.....Conneaut
Jones, Edward H., Jr.....Youngstown
Jones, Stewart R.....Cincinnati
Keogh, Joseph P.....Youngstown
Kerschgens, Lambert J.....Toronto
Pelegrin, Ralph J.....Cleveland
Sherman, John J.....Ironton
Smith, Richard N.....Wooster
Stage, John Taylor, Jr.....Ashland

Oklahoma

Cunningham, John A.....Ada
McKinney, Milam F.....Oklahoma City
Stickle, Arthur W.....Oklahoma City

Oregon

Haugen, Gerhard B.....Portland
Joseph, Robert E.....Portland
Rodda, James M.....Portland

Pennsylvania

Cohen, Harold M.....Pittsburgh
Drapiewski, Joseph A.....Nanticoke
Elliott, Frank R.....Reading
Farrell, Harry L.....Philadelphia
Fetterman, George H.....Castle Shannon
Flook, Samuel E.....Philadelphia
Flory, Clyde R.....Sellersville
Gibbs, Albert G.....West Nanticoke
Good, Ralph D.....Wilkinsburg
Hallowell, Albert V.....North Wales

Pennsylvania—Continued

Hamilton, Aubrey H.....Philadelphia
Hooker, Edgar F.....Bryn Mawr
Jacobs, John B.....Lansdale
Kagen, Gordon A.....Philadelphia
Kooser, John Herman.....Irwin
Lehman, John F.....Yeadon
McNeil, Robert J., Jr.....Philadelphia
McNerney, John C.....Philadelphia
Muir, Donald C.....Greensburg
Murchison, Edwin B.....Tyrone
Murphy, John T.....Oliphant
Nicholson, John W., III.....Bryn Mawr
Northrop, David D.....Philadelphia
Patterson, William B.....Crafton
Paull, Thomas.....Barre
Pote, Harry Harvey.....Philadelphia
Royster, Hubert A., Jr.....Bryn Mawr
Shumway, Norman P.....Philadelphia
Shutt, Thomas J.....Jenkintown
Speelman, James W.....Pittsburgh
Stevens, Selton S.....Scranton
Stewart, William P.....Philadelphia
Swick, Jesse H. II.....Beaver Falls
Weston, Kenneth R.....Allentown
Wible, Leroy E.....Pittsburgh

Wisconsin

Aiken, George R.....Bremerton
Biehn, Roy C.....Lakeside
Brazy, Robert R.....Milwaukee
Bruskewitz, Harold W.....Milwaukee
Burpee, George F.....Edgerton
Burzynski, Eugene E.....Watertown
Callaghan, Desmond H.....Hayward
Carroll, Gordon E.....Janesville
Charles, John D.....Wauwatosa
Cowan, Irving I.....Milwaukee
Creswell, Clifford M.....Kenosha
Cunningham, Paul M.....Madison
Dana, Robert L.....Fond du Lac
Davee, Chalmer.....River Falls
Dunst, Carl G.....Milwaukee
Eck, Gustave E.....Lake Mills
Fein, Norman N.....Milwaukee
Feldman, Edward I.....Milwaukee
Foster, Mark A.....Madison
Golden, Farrell F.....Ashland
Grundahl, Alvin T.....Mayville
Hanson, Oscar H.....Fort Atkinson
Helmbrecht, Milan G.....Elkhorn
Henke, Samuel L.....Eau Claire
Hudson, Edward D.....Lake Geneva
Ihle, Charles M.....Eau Claire
Jochinsen, Marvin A.....Milwaukee
Kiefer, Edward J.....Milwaukee
Kindshi, Leslie G.....Monroe
King, James J.....Milwaukee
Kinsey, Jack L. V.....Milwaukee
Klopf, Howard M.....Milwaukee
Kroyer, Theodore J.....Walworth
Leonard, Thomas A.....Madison
Moon, Rodger A.....Neenah
Neacy, Clement F.....Williamsburg
Newcomb, Charles J.....Milwaukee
Newman, Carl R.....Tomahawk
Paquette, Louis J.....Milwaukee
Parke, George Jr.....Richland Center
Pawsat, Ewald H.....Fond du Lac
Peckham, Ben M.....Milwaukee
Quincannon, Francis J.....Lake Geneva
Rauen, Leonard M.....Kenosha
Rikkers, Donald F.....Augusta
Ruehlman, David D.....Monroe
Schelble, John P.....Milwaukee
Scheyer, Carl J.....Puyallup
Schnoebelen, Rene E.....Muscuda
Schoenkerman, Bert B.....Milwaukee
Schulte, George C.....Kenosha
Sherman, Lloyd F.....Siren
Thompson, Richard D.....Milwaukee
Vander Kamp, Harry .....Baraboo
Werner, David J.....Milwaukee
Werra, Bernard J.....Wauwatosa
Worm, George J.....Wauwatosa

ORGANIZATION SECTION

THE WAGNER-MURRAY-DINGELL BILL

Hearings on S. 1606—To Provide for a National Health Program

(NOTE.—*This is a condensation of the verbatim report of the hearings.*—ED.)

(Continued from page 1179)

United States Senate, Committee on Education and Labor.
APRIL 5, 1946

HONORABLE JAMES E. MURRAY Presiding

PRESENT: Senators Murray, Ellender, Aiken and Donnell.

Statements of William Logan Martin, Representing the American Bar Association, and Walter M. Bastian, Treasurer of the American Bar Association

Mr. Martin presented the report of his committee on the previous bill, S. 1161. He stated that the approximate membership of the American Bar Association is 35,000, the largest in the history of the association. The report was presented to the American Bar Association by a committtee of which Mr. W. E. Stanley, Kansas, is chairman, and he and Mr. Clement F. Robinson are the other members.

The House of Delegates of the American Bar Association had adopted the report.

Mr. Martin described the constitution of the House of Delegates of the American Bar Association and the study of health insurance made by the committee.

SENATOR DONNELL: Now, you have not examined S. 1606, the pending measure? MR. MARTIN: I have, Senator.

SENATOR DONNELL: Would you tell us, please, what your opinion is generally of S. 1606 and the reasons therefor. MR. MARTIN: I think it is more extensive than S. 1161. The substantial differences which I found in comparing the two bills I will indicate in short: The Surgeon General, under the new bill, performs his duties under the supervision of the federal security administrator, whereas formerly he was supreme in the performance of his duties. Second, the Surgeon General may delegate to any federal or state official any of his duties except that of prescribing rules and regulations. He may appoint local area committees selected from panels of names submitted by local individuals or agencies.

The physical foundation is different in the later bill. A sum is appropriated sufficient to defray the expenses of the enterprise, while at the same time there is to be credited to that appropriation 3 per cent of the wages paid and on which, my recollection is, social security taxes are now based. Authority is granted for the appointment of sufficient personnel under Civil Service to carry out the scheme. The Surgeon General is required to make a full report to Congress.

He may make payment by any other method than that agreed on by a majority of the doctors who are on a panel to the doctors who do not elect the method adopted by the majority. Payments are to be adequate, based on customary annual income of the doctors employed. The Surgeon General is to exercise no supervision or control over participating hospitals, and no agreement entered into by participating hospitals with the Surgeon General shall prescribe its administration, personnel or operation.

The scheme is more extensive in that it includes dental and nursing benefits, whereas these were not included in the former bill.

The definition of wages is somewhat different in that it apparently adopts the plan, or, I will leave out "apparently," it does adopt a plan by which it lists the wages on which the tax is to be imposed, excluding a number of classes of wage earners, whereas heretofore it simply referred to a certain section of the Social Security Act which contained the listing of deductions or exemptions from the tax.

SENATOR DONNELL: Now, Mr. Martin, would you be kind enough to state as to the fundamental principles which you find embodied in S. 1606 whether or not your observations would differ materially from those set forth in the conclusions with respect to S. 1161 contained in the report which has already been presented by you this morning. MR. MARTIN: My view would not differ at all.

SENATOR DONNELL: And were you to have before you personally S. 1606 at this time just as you had, as a member of the committee, S. 1161 in 1943 and 1944, what would be your net conclusion and advice to our committee as to your opinion respecting S. 1606, whether it is wise or unwise legislation, and the reason for your conclusion? MR. MARTIN: Well, I think the judgment of the Bar Association would be the same.

SENATOR DONNELL: What is your own personal conclusion, if you do not mind telling it to us, Mr. Martin? MR. MARTIN: My personal conclusion, Senator, is that it is probably the most extensive undertaking made by Congress beyond the limits of the Constitution of this country. I cannot conceive that a bill which goes so far as this into the intimate details of the lives of American citizens can be justified under the Constitution of the United States.

SENATOR DONNELL: Do you mind telling us, briefly, those principles or express provisions of the Constitution to which you refer? MR. MARTIN: The Tenth Amendment particularly.

SENATOR DONNELL: Which reserves to the states and to the people the powers not expressly or impliedly conveyed to the federal government? MR. MARTIN: That is correct. If a state government, for instance, wanted to adopt a scheme of this kind, it has a perfect right to do so, and the people have a right to do so in the states; but, as I see the government of this country, it never would have been formed if the founders had ever had the faintest idea that Congress would ever undertake such an enterprise as this.

SENATOR DONNELL: Mr. Martin, is there anything further that you would desire to state on the general question that I have asked you? MR. MARTIN: Well, in studying this matter the last few days, since I was notified I would be selected to appear here, there came to my mind a paragraph in Washington's farewell address, and I was impressed that it applied to the situation today, and it was just as apt today as it was when he delivered it 140 years ago, and I would like to put that in the record.

SENATOR DONNELL: We would be glad to have you do so. MR. MARTIN: He said:

"Toward the preservation of your government and the permanence of your present happy state, it is requisite, not only that you steadily discountenance irregular oppositions to its acknowledged authority, but also that you resist with care the spirit of innovation upon its principles, however specious the pretexts. One method of assault may be to effect, in the forms of the Constitution, alterations which will impair the energy of the system and thus to undermine what cannot be directly overthrown. In all the changes to which you may be invited, remember that time and habit are at least as necessary to fix the true character of governments, as of other human institutions—that experience is the surest standard by which to test the real tendency of the existing constitution of a country—that facility in changes upon the credit of mere hypothesis and opinion exposes to perpetual change, from the endless variety of hypothesis and opinion. . . ."

Now, I do not think any one has ever questioned Washington's leadership, patriotism, wisdom, courage and love of country, and that is a very impressive thing to me.

Now, for the last decade in this country we have seen irregular oppositions to the acknowledged authority of the govern-

ment, the Constitution has been said to be outmoded, and we need a new government, but the Constitution provides its method of amendment. There has grown up a spirit of innovation on the principles of the Constitution, on many specious pretexts. Here, by Senate bill 1606, the federal government proposes to take over the mental and physical necessities of all the people and interpose its activity between the intimate relationship of the doctor and the patient, all in direct conflict with the Tenth Amendment to the Constitution, which reserves to the states and to the people thereof all power and authority not expressly or impliedly delegated to Congress. Thus, Congress would undermine what could not be directly overthrown. We had thought that time and habit and experience had fixed the true character of our government, but here an extraordinary change in our governmental structure is proposed, based on hypothesis and opinion. The hypothesis is that a certain sector of the people do not receive sufficient medical care, and it is the opinion of the proponents of Senate 1606 that Congress can remedy the situation by setting up a gigantic scheme under the control of one man, by which the government would take over all medical care, supervising doctors, dentists, nurses and hospitals. Such an undertaking on such a basis, to quote Washington's phrase "exposes to perpetual change, from the endless variety of hypothesis and opinion."

(Mr. Martin stated his career in law and in the American Bar Association.)

MR. BASTIAN: The judge neglected to say that he had been a member of the board of governors since 1943, and with all of his modesty I will say that he is one of the most distinguished lawyers in the state of Alabama and is so regarded.

SENATOR DONNELL: May I have Mr. Bastian identify himself? MR. BASTIAN: I am the treasurer of the American Bar Association and a member of the board of governors, Walter M. Bastian, National Press Building, Washington, D.C.

(Mr. Martin stated his career in law and in the American Bar Association.)

SENATOR MURRAY: The American Bar Association is also recognized in the country as a very conservative organization? MR. MARTIN: I could not say that. I think the American Bar Association, if you divide bodies of lawyers into two sectors and if you call the Lawyers Guild the radical element, then the American Bar is its conservative element.

(Senator Murray cross questioned Mr. Martin, endeavoring to prove the conservative character of the American Bar Association.)

(Senator Donnell pointed out that officers of the Lawyers' Guild were also chiefly city lawyers.)

SENATOR MURRAY: You are familiar with the Blue Cross plans? MR. MARTIN: To some extent. For a maximum payment of $49 a year, any size family from two to twenty can get the medical service it needs, that is $4 a month.

SENATOR MURRAY: Have you made any study of the problem of these families with an income of from $2,000 to $3,000 a year, with regard to their need of borrowing funds for the purpose and starting themselves in a downward spiral as a result of the indebtedness that they have taken on, frequently to pay medical care expenses? MR. MARTIN: I have made no such study, Mr. Chairman, but it would not be a great problem to borrow $49 a year.

SENATOR DONNELL: Mr. Martin, pardon me, what did you mean by the statement that you had not made a careful study of the Blue Cross? MR. MARTIN: Well, I have not examined the details of every Blue Cross system in the United States. I do not know how many each covers, and I do not know the cost of each, but I know in a general way the number covered by the plans.

SENATOR DONNELL: What affirmative study have you made of the Blue Cross, so that we may know as to the extent of the coverage?

MR. MARTIN: Well, in the preparation of this report I secured a great deal of literature, from different sources, and I analyzed it and digested it into a brief here of some twenty-seven pages. I studied the literature of countries with some kind of health insurance, the plan of the dominion of Canada, the system in Germany, in England, in Russia and in Europe, and I studied the expenditures in the United States for medical services, the progress of medicine in the United States compared with that of European countries, the hospitals in the United States, medical services in the United States, hospital insurance, Blue Cross hospital plans, health insurance, nonprofit and governmental hospitals, voluntary hospitals, indigent care and the cost thereof, and relationship between doctor and patient. There is an index of the subjects which I compiled from my study of the literature on the subject.

SENATOR DONNELL: I gather that you have made some study although you do not mean to state that it is an exhaustive complete study of the Blue Cross. Is that correct? MR. MARTIN: That is correct. I had overlooked for the moment this study made two years ago or three years ago.

SENATOR DONNELL: And in your response to Chairman Murray in which you stated that you had not made a careful study, do you mean to say that you made a study that was lacking in care or that you simply had not made a comprehensive and complete study? MR. MARTIN: I have not made an exhaustive study.

SENATOR DONNELL: Now in regard to the exact figures, for instance the 40,000,000 figure that I think you mentioned, are you undertaking to state with accuracy the figures or are you giving your best recollection? MR. MARTIN: I had better break that figure down. There are 40,000,000 people in this country covered by the Blue Cross plans and the plans which are fostered by insurance companies. Such is my information.

SENATOR DONNELL: You are using the Blue Cross as a generic term for voluntary insurance? MR. MARTIN: Where premiums are paid for the service.

SENATOR DONNELL: You are not confining the use of the Blue Cross to some organization that calls itself the Blue Cross? MR. MARTIN: No. I think there are 21,000,000 today under the Blue Cross plans and that number is increasing at the rate of 5,000,000 a year.

SENATOR DONNELL: As to the coverage, is it not true that ordinarily the Blue Cross does cover only bed and board in the hospital and not surgeon's fees, or do you know?

MR. MARTIN: I think that was the case originally, but it is greatly extended now, as in my own state, which I referred to, where it now covers medical service.

SENATOR DONNELL: Now, in view of the courtesy of Mr. Bastian in coming, if I might ask him to tell us why Mr. Martin is here this morning and what if anything occurred in the way of polling the board of governors of the American Bar Association.

MR. BASTIAN: We received an invitation from the distinguished chairman of this committee to be present, so our appearance is not a voluntary one but is a result of an invitation very generously extended. The president of our Association and the chairman of the house of delegates, Mr. Willis Smith of North Carolina, is president and Mr. Gregory of Illinois is chairman of the house of delegates—are now at Nuremburg at the invitation of the War Department observing the war crime trials. The administrative committee of the American Bar Association met in Chicago the early part of March, and that committee consisted of the president and the chairman of the house, who are absent, the secretary, the chairman of the budget committee, who comes from the same state as our distinguished chairman, and the chairman of the committee on sections, who comes from Delaware, and myself, so that we had four out of the six members present.

We examined the invitation of the chairman of the committee and polled the board as to whether or not we would designate Mr. Martin to be present, because of the study which he had made, to speak on the former proposed legislation. The Bar Association had not passed on S. 1606, but we thought it would be of interest to the committee to hear our views on the previous bill, and hence the presence of Mr. Martin today.

I might say that the polls were unanimous in the authorization of Mr. Martin.

SENATOR MURRAY: I was going to ask Mr. Martin if he had made any study of the reports of the Selective Service Administration in connection with the examination of the young men of this country during the recent war. MR. MARTIN: No, I have not.

SENATOR MURRAY: And you are not familiar with the fact that there had been a very large percentage of American youth rejected as defective due to the fact that their health had been neglected? MR. MARTIN: From general reading, yes, I was aware of that fact.

SENATOR MURRAY: And you know that that situation prevails in the country quite generally, that there are a great many people who because of their failure to get adequate medical care in time, have greatly impaired their health? MR. MARTIN: I suppose so. My eyes are bad, and I perhaps did not have the care in my youth that I should have had, but I cannot have perfect eyes, and everybody cannot have perfect eyes, and everybody cannot have perfect health unless we are all going to be perfect. We are human beings.

SENATOR MURRAY: But the health of the American people would be greatly improved if there was some way in which

they could have ready access to modern medical advice and care? MR. MARTIN: I should think so.

SENATOR MURRAY: It would greatly benefit American industry and American business too, would it not, if we had a system of health care in this country where people would not hesitate to go and consult their physicians and take care of their health in time before their health became seriously impaired? MR. MARTIN: I think that we should have a real elysium if there were no ills at all. We would have a wonderful country if nobody ever got sick or nobody had an ailment.

SENATOR MURRAY: Do you think that that is the aim of this bill, to have nobody ever get sick? MR. MARTIN: No, I do not think so. I do not think that that is possible.

SENATOR MURRAY: Of course not. Why would you make that observation then? I do not think that that is called for in an answer to my question. It does not seem to me that anybody would ever expect to have any such a situation as that kind, but there could be a great improvement in the national health if we had some system whereby people would not hesitate, and where they would not feel as a result of the cost of medical care that they would not be able to go and get it at the proper time. MR. MARTIN: Yes, and with an expenditure of four and a half billions of dollars, or three billions of dollars, or whatever it is, of course there is bound to be a favorable result from it.

SENATOR DONNELL: You mentioned or the chairman mentioned governmental participation. As I understood it you were pointing out that as between the state governments and the federal government you do not believe that this health insurance plan is a function of the federal government, that if the government is to intervene in the matter it is a problem and function of state governments as distinguished from the federal government? MR. MARTIN: Under our present form of government, that is correct.

Statement of Leo J. Linder, National Lawyers Guild

Mr. Linder, said that he is a lawyer admitted to practice in New York.

MR. LINDER: The report of the National Committee adopted by the National Lawyers' Guild strongly supports the National Health Act and regards the National Health Act as legislation of paramount importance and benefit to the American people.

We believe that the existing arrangements for providing medical care accordingly need much improvement, and we are satisfied that the insurance principle of pooling costs and risks so that persons can be paid out of a common fund when and where and as often as they need care should be applied.

We believe that the difficulty with voluntary private insurance is that it involves a small pool restricted to a limited group, and we observe that the necessity of protecting the solvency of the fund results in a limitation of protection of private voluntary plans to certain specified medical services and also to large cost.

We thus conclude that voluntary private insurance is too restrictive in benefits and too high in cost to be serviceable for more than a small minority of the American people.

We believe that social insurance, which involves distributing the risks over virtually the entire nation, is clearly the cheapest and most effective means of dealing with the problem; and we believe that national social insurance and a national health fund is enormously preferable to any statewide compulsory social insurance system.

SENATOR ELLENDER: How much smaller is the per capita cost under the pending measure than it is under the system of voluntary insurance? MR. LINDER: Much smaller, Senator.

SENATOR ELLENDER: I would like to know Why is that? I understand that these plans are voluntary and on a nonprofit basis. MR. LINDER: That is correct. The difficulty is that in order to protect the solvency of the fund the private insurance societies are necessarily restricted in scope. I am a member of the Blue Cross system in New York City and I pay $24 a year, but the only service I get under that Blue Cross policy that I have is a limited hospital service. I get no medical care at all for myself and for the members of my family.

SENATOR ELLENDER: Could you get more if you paid more? MR. LINDER: There are other systems. I also have a health and accident insurance policy which costs me $60 a year and gives me very limited coverage after a thirty day waiting period and for a limited period. I also pay—27 times 4—a little over $100 a year to another health and accident insurance company that provides also very inadequate and limited coverage.

I can say without qualification at all that the benefits which would be provided under the Wagner-Murray-Dingell bill would be enormously greater than the benefits I get under all three systems of private protection which I have personally resorted to as a means of protecting myself and my family.

SENATOR ELLENDER: Do not some of those policies you have now protect you not only for medical care but give you a weekly or monthly stipend? MR. LINDER: That is correct.

SENATOR ELLENDER: Is it your view that this Blue Cross is limited to such an extent that it could not provide the necessary care for sick people? MR. LINDER: I have not the slightest doubt that Blue Cross could not, without going bankrupt, provide the medical care that is provided in the Wagner-Murray-Dingell bill unless the premiums were three to four times the present premiums.

I should like to say, Senator, that this part of my discussion is a discussion in which I think I am less expert than the portion of my testimony that I would like to now go into, which deals with legal matters. I can speak of my own personal knowledge with respect to personal experience with respect to Blue Cross, but I think your committee would be better served if you let experts in the field of public health and experts who have examined the data with respect to that talk to you.

With respect to the matter of constitutionality, I notice that the report of the American Bar Association presented here this morning contains one sentence on constitutionality. It states "S. 1161 is utterly beyond the powers of Congress." I would like to submit, gentlemen, that the matter of constitutionality of this legislation is decisively determined by the decisions of the United States Supreme Court dealing with the social security cases. I note that in one of them, Steward Machine Company against Davis, 301 U. S. 548, Mr. William Logan Martin, who appeared here this morning, was counsel for petitioner asserting the unconstitutionality of the unemployment compensation provisions of the Social Security Act; and while he is unquestionably entitled to his personal opinion, the United States Supreme Court did not adopt that opinion, and so he is still averring unconstitutionality in the face of the authority determination of our highest court.

SENATOR DONNELL: Mr. Chairman, I submit that the highest court of our land did not have this bill before it. The matters before it were social security legislation now on the books.

MR. LINDER: Our analysis of the American Bar Association report leads us to the conclusion that that report, I regret to say, contains many errors of fact, many serious errors of interpretation, and abounds in conclusions which are unwarranted and totally unjustified.

(Mr. Linder made an extensive answer to the criticisms of the American Bar Association and insisted the bill grants free choice of physician.)

SENATOR DONNELL: For instance, if you do not mind my interruption, in subdivision (j), section 205, it is prescribed that the Surgeon General may prescribe maximum limits and the number of potential beneficiaries for whom a practitioner may undertake to furnish general medical or general dental benefits. MR. LINDER: Yes.

SENATOR DONNELL: For instance, if the Surgeon General stated, say, that Dr. Jones in Sedalia, Mo., is limited to 50 potential beneficiaries that he may treat, and I happen to live there, and I am number 51, and I want Dr. Jones, who is my old family physician; but since I am number 51 I cannot get him under that section of the bill. Am I correct on that or not? MR. LINDER: Senator, your assumption is an assumption which I cannot entertain. It is an assumption of so unreasonable a regulation that it would be nugatory and ineffective.

SENATOR DONNELL: You mean that 50 may be too low? MR. LINDER: It may be too low.

SENATOR DONNELL: Suppose it is 250 and I am number 251; I cannot get the services of Dr. Jones if I happen to be the one next man beyond the 250. Am I correct, or am I not? MR. LINDER: I must make an answer in two sections. SENATOR DONNELL: Could you make it "yes" or "no" first? MR. LINDER: I do not think a "yes" or "no" answer would intelligently give you the information you desire.

SENATOR DONNELL: Very well. MR. LINDER: First, (j) only applies to the per capita compensation. It has no application where a per capita arrangement has not been adopted by the doctors. That is the first point that you must understand.

Now, if the majority of the doctors in Sedalia, Mo., decide that they do not want to be paid on a fee basis, that they do not want to be paid on a salary basis, that they want to be paid on a per capita basis; that is to say, that they want to be paid according to the number of patients they serve, and assuming that they have done so; and assuming, second, that there are 500 people in Sedalia, and that with 500 people to be served and

with a limited number of doctors to serve them, and with the doctors having agreed on by majority vote a per capita basis, then if a regulation is imposed the regulation would have to be reasonable, and if it was not reasonable the doctors or the patients could take it up on review; and if it were reasonable, Senator, where no doctor would take you, and you had been refused by every doctor, then it might be that a reasonable regulation might require you to be assigned to a doctor regardless of your preference or the doctor's preference; but you would have to get that extraordinarily remote situation. That situation would have to apply only in such an unusual case as that before you could have any possible dissatisfaction.

The scheme of this bill, as set forth in the sections which I have read, is that all the doctors in Sedalia, Mo., have a right to treat patients within the system if they want to. If they do not want to they are not compelled to do so. If they prefer to treat only the wealthier people in the community who can pay them more substantial fees commensurate with what they regard to be the value of their services, they need not serve the people taken care of here. That is number one.

Number two, every person in Sedalia, Mo., who is covered has a choice of going to any doctor on the list, and every doctor who wants to be and is qualified under the laws of the state of Missouri is entitled to be on the list.

How is the doctor to be paid? The doctor is to be paid according to the vote of the majority of the doctors in Sedalia. The majority can decide whether they want to be paid according to a fee schedule. They can decide that they want to be paid on a salary basis. They can decide that they want to be paid on a per capita basis. They can decide that they want to be paid on a combination of these.

It seems to me that our belief in democracy ought to extend to our belief in applying democratic principles to the doctors as well. If the doctors understand that the people in Sedalia, Mo., cannot get adequate medical care unless the costs of medical care are insured, then it would seem to me again that the doctors in Sedalia, Mo., ought to recommend this arrangement, because here for the first time the patients are sure of service and here for the first time he is sure of his fee.

Now, the only difference in the relationship between the doctor and the patient provided here is that the doctor, instead of saying to his patient after he has finished his ministrations "My fee is so many dollars," the doctor says "I have noted the service given." And he then is paid by the government.

Now, if I should break a leg and under my policy after my doctor has treated me I should ask my doctor to send his bill to the insurance company, I would not think he was being socialized, and most doctors would be entirely satisfied too.

All that this bill does is that it insures everybody in the way that I am now insured when I personally buy private insurance, which I can afford to buy, but which many people cannot.

What is involved here is essentially an extension of the principles of workmen's compensation. It would be preposterous to suggest that workmen's compensation is socialized medicine or involves bureaucratic interference with the rights and privileges of free men, because we all understand that workmen's compensation creates a situation that when a worker is injured he gets the attention he needs.

SENATOR ELLENDER: I tried to develop this situation with Mr. Altmeyer yesterday, and if I understood him well he agrees with the American Bar Association that there is not complete freedom of choice of doctors by patients as quoted here by you on page 14 and attributed to Senator Wagner for the simple reason that in order for me to be able to get my family physician my family physician must be a part of this whole scheme. MR. LINDER: Not at all. SENATOR ELLENDER: Yes, he must. MR. LINDER: Senator—

SENATOR ELLENDER: Wait a minute, now. On page 46 of the bill it is stated in this subdivision (e) of section 205. MR. LINDER: I have it.

SENATOR ELLENDER: "The Surgeon General shall publish and otherwise make known in each local area to individuals entitled to benefit under this title the names of medical and dental practitioners and groups of practitioners who have agreed to furnish services as benefits under this title and to make such lists of names readily available to individuals entitled to benefits under this title."

Now, if in my community you have 25 doctors and only 10 comply with this section, what would happen? MR. LINDER: Only 10 legally qualified?

SENATOR ELLENDER: No, not legally qualified. I am assuming that the 25 are qualified. MR. LINDER: But only 10 have agreed to serve?

SENATOR ELLENDER: Yes, only 10 have agreed to comply with subsection (e). These 10 would be put on that list and the rest of them in the amount of 15 would be left out. If my family physician is among that 15 then I cannot call him? MR. LINDER: Sure you can.

SENATOR ELLENDER: Unless I pay for it? MR. LINDER: That is right.

SENATOR DONNELL: In addition to the fact that he would have been charged the other taxation on the plan.

MR. LINDER: What about a public school system? If you do not want to send your child to a public school you do not have to, but you have to pay for it. SENATOR ELLENDER: I understand.

MR. LINDER: That is the same point. SENATOR ELLENDER: No, it is not, because you say that the American Bar Association is wrong in its conclusion. I say that you are wrong.

SENATOR DONNELL: Mr. Chairman, without any criticism of Mr. Linder, because I can see his concern and his interest in this matter and his desire to elucidate his theories, the question I asked him could be answered "yes" or "no" with an explanation; and I dare say that if Mr. Linder had a witness on the stand and he asked him that question he would insist on the question being answered "yes" or "no." MR. LINDER: What is the question?

SENATOR DONNELL: The question, as nearly as I recall, if I live in Sedalia, Mo., which I do not, but if I live in Sedalia, Mo.—and here I am going to change that so as to get the name of my home town in. If I live in Webster Groves, Mo., which is one of the charming and delightful suburbs of the city of St. Louis, if I live there and my doctor is Dr. Jones, under the present situation I have a right to request him to serve me, and if he is willing he has no restrictions in so doing. Is that correct? MR. LINDER: Right.

SENATOR DONNELL: Under the provisions of this subsection of section 205, S. 1606, as I understand it, and I am quoting, "The Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit." That is correct, is it not? MR. LINDER: That is right.

SENATOR DONNELL: We will assume, therefore, that the Surgeon General says that in Webster Groves, Mo., no doctor may take more than 250 patients. MR. LINDER: You are assuming now that the doctors have agreed on the per capita basis.

SENATOR DONNELL: And after they have assumed it they have therefore come under the operation of the bill, which they can do or not do. Am I right? MR. LINDER: That is right.

SENATOR DONNELL: Say they do in Webster Groves, Mo., because of what was pointed out here yesterday, the fact that this may increase their income, which is entirely proper for them to take into their minds, they do agree on accepting the terms of the bill; and there is a limitation placed so that Dr. Jones may take only 250 patients. My question, as nearly as I can recall it, was, asuming all these facts, that in the city of Webster Groves the doctors by majority vote have decided Dr. Jones can have only 250 patients, and that majority vote is taken as part of the system of S. 1606, and Dr. Jones, who is my close and intimate friend and personal physician, finds himself limited to 250 patients; and I walk into his office with a high fever. I am therefore number 251. MR. LINDER: Why are you 251? Why are you not in the 250?

SENATOR DONNELL: The 250 have been there before me. MR. LINDER: I see.

SENATOR DONNELL: There are 250 on the list before me, and I walk in as 251. Dr. Jones cannot, as I read this section, treat me regardless of the extremity under which I may be. MR. LINDER: I think that is a normal procedure.

SENATOR DONNELL: The question is, am I correct or not correct in my understanding? I think that the witness can answer that "yes" or "no." MR. LINDER: The answer is "yes."

SENATOR DONNELL: I am correct. MR. LINDER: Yes.

SENATOR DONNELL: What is your explanation? MR. LINDER: I say the answer is "yes"; and I do not think that is any more terrible than if you went to your doctor and he was busy delivering a baby and he said "I cannot take care of you; I am busy." The point is that common sense imposes reasonable restrictions. If it were reasonable that in Webster Groves there should only be 250 patients for one doctor, and if you had not diligently notified the doctor that you wanted to be one of his 250, that, as I understand it, is your misfortune,

just one of the trifling incidents of operating a system of medical care. The thing I want to make clear, Senator, is that you must never forget subdivision (g) of section 203 of the act.

SENATOR DONNELL: Now, Mr. Chairman, it would be a little difficult for me to be carrying around this act with me all the time. MR. LINDER: You have to pass on it.

SENATOR DONNELL: Mr. Chairman, I doubt very much if I could prevent my fever from rising to a very high point if I did. MR. LINDER: Now, subdivision (g) of section 203—"The Surgeon General, after consultation with the board, and after consultation with the advisory council as to questions of general policy and administration, and with the approval of the federal security administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this act, as may be necessary to the efficient administration of this title."
And then there is a proviso that is not pertinent to what I am going to say.

The sense of that section is that all regulations must be reasonable. All regulations must be designed within the spirit of the act. All regulations must be designed to carry into effect subdivision (f) of section 205, which says that the methods of administration shall insure the prompt and efficient care of individuals entitled to personal health service benefits, promote personal relationships between physician and patient, provide professional and financial incentives for the professional advancement of practitioners, and so on. The point is that you must not assume an unreasonable regulation and then beat this legislation with the stick of that unreasonable assumption.

SENATOR DONNELL: In the first place, I do not think the regulation I assumed was unreasonable within the four corners of this bill. You have to have some figure provided under subdivision (j) of section 205. I have selected a figure. MR. LINDER: Which is unreasonable.

SENATOR DONNELL: If you think it is, tell me why it is. SENATOR MURRAY: Assuming that it is reasonable, would there be anything unreasonable in the Surgeon General's permitting him to take 1 more patient? Would that not be a reasonable thing to assume, if he insisted on having that doctor, that the Surgeon General would say "All right; you may have that doctor." MR. LINDER: Of course.

SENATOR DONNELL: So far as I have observed the bill does not say that. SENATOR MURRAY: I know.

SENATOR DONNELL: I do not want to have a prolonged argument, because we will have to settle all these things, but I would like to get Mr. Linder's ideas. This says that the Surgeon General may prescribe these maximum limits of potential beneficiaries, which is the maximum number of patients, which maximum limits may be nationally uniform or may be adapted to take account of relevant factors. MR. LINDER: That is right.

SENATOR DONNELL: The point I am making is that the Surgeon General has a right to make a limit beyond which Dr. Jones, after this majority vote of the doctors in Webster Groves, cannot go. MR. LINDER: May I interrupt a moment?

SENATOR DONNELL: If I may finish, please. Point number two: I realize what Mr. Linder has expressed as regards the reasonableness of regulations, and yet there is not a man, woman or child, if there be any in this room this morning, that has not heard of unreasonable regulations in the administration of bureaucratic affairs in our government. MR. LINDER: That is what the courts are for.

SENATOR DONNELL: I do not want to go to court. MR. LINDER: Why not?

SENATOR DONNELL: If I had a fever. MR. LINDER: What would you do if you had a fever and could not get a doctor?

SENATOR DONNELL: I want to say two things; first, that to my mind there is an exceedingly unreasonable policy in allowing the majority of doctors in the city of Webster Groves, Mo., to put it in the power of any individual board or combination of boards to say how many patients Dr. Jones on Gore Avenue can take; and I say there is strong reason and view that Dr. Jones should not be restricted in determining the persons whom he will serve. Nor should the patient, perhaps in extreme cases, like emergencies, be required to rely on some regulation in Washington, perhaps even having to go to court to enforce his rights, as Mr. Linder indicates.

MR. LINDER: There must be a maximum limitation on the number of patients to be served by doctors, or otherwise you would have a situation where the doctors would be overburdened and the patients could not get decent service.

SENATOR DONNELL: Is there any such limitation now under the law of our country as to the number of patients the doctor may take? Is that not left to the good judgment of the doctor himself? And has not our spirit of American enterprise and personal adjustment found it necessary to leave that to Dr. Jones rather than somebody in Washington? MR. LINDER: First of all, the doctors and people in Webster Groves would for all practical purposes determine the situation. There are a whole series of specific provisions providing for local areas and their administration, so the suggestion that this is something that the Surgeon General will be soothing your fevered brow in Webster Groves is fantastic, with all due respect, Senator. Only the doctor in Webster Groves could take care of you. And it makes sense also that in Webster Groves reasonable limitations should be placed on the number of patients any one doctor should take care of. It seems to me, Senator, that you must approach the whole question from this standpoint. I do not know anything about Webster Groves, but assuming that it is a community in which there are poor people and people of small income, the fact is that the majority of the people of small income and medium sized income in the United States are not in a position to meet the costs of medical care when a catastrophe occurs. The fact is that one third of the people of the country do not get any medical care, if our own government reports are to be believed.

SENATOR DONNELL: May I ask the witness at that point, Mr. Chairman: you are relying, are you not, Mr. Linder, on a statement printed in 1939 based on studies of the Committee on the Costs of Medical Care made in 1929, 1930 and 1931? MR. LINDER: Yes.

. . . . . .

SENATOR MURRAY: Is not this right to select somewhat overexaggerated? I know a case from my state of Montana where a member of my family traveled to Baltimore to be operated on by a well known physician. When she got there she found out she could not have his services, was operated on by a total stranger and was entirely satisfied in every respect. I think there is gross exaggeration there. MR. LINDER: I think so too.

SENATOR MURRAY: And I think in the Army the boys did not select the surgeons that operated on them over in the battlefields, and they were treated pretty well. MR. LINDER: They got better medical care than most of them had got in their lives.

SENATOR MURRAY: That is right. They were benefited in health in every way. MR. LINDER: I think the whole subject of free choice of doctors is an exaggerated, hysterical "bugaboo" that has no real relationship to reality. The truth of the matter is that our choice of doctors is restricted. It is restricted by the number of doctors available. It is restricted by the amount of money we have got. It is restricted by the willingness and the ability of the doctors to take us on. It is restricted by many, many different factors.

SENATOR DONNELL: But not by any governmental prohibition against his taking the case! MR. LINDER: So what?

SENATOR DONNELL: There is a very great difference between restriction by governmental prohibition against a doctor taking on a case and an economic and professional situation which makes it impossible for him to do so. The one point is governmental discipline, direct compulsion, while the other is a situation which arises under the operation of natural forces uninfluenced by governmental regimentation. MR. LINDER: Senator, if you had a violent "bellyache" and you had no doctor except the Public Health surgeon, you would be tickled to death and thank God for the public surgeon.

SENATOR DONNELL: But if, on the other hand, I had a choice between the Public Health surgeon, whom I do not know, and Dr. Jones of Webster Groves, whom I do know, I would want Dr. Jones to treat me. MR. LINDER: And there is nothing in the bill which prohibits Dr. Jones from treating you.

SENATOR MURRAY: It seems to me that we are living in a democracy. We are living in a democracy, and if the majority of the people want some sort of national health insurance which will enable them to have access to modern medical care, I think they should be able to have it, regardless of the fact that a few people make carping criticisms and objections. You could oppose every beneficial measure ever enacted by Congress for the welfare of the people if you wanted to be technical. I do not think any law is absolutely perfect or could be justified 100 per cent. It is the general benefit involved. I would like to ask Mr. Watson Miller to make an observation. He has been a witness here.

MR. MILLER: I have been very much interested in this colloquy, and I do not desire to gild the lily or paint the rose. I much appreciate the spirit of democracy, the Senator's good humor and his self control and interest. It seems to me that the 250 people we are talking about could be defined in such a manner as this: that that represents a figure of not necessarily individuals. For instance, I might want a doctor as a surgeon, but not in obstetric work. It could be elastic in that system being discussed here indicated in this colloquy.

SENATOR DONNELL: I would like to thank Mr. Miller for his very kind expression toward me, and I assume toward Mr. Linder also. We realize this is not a personal matter, but one in which we are all concerned.

MR. MILLER: In that expression I did not mean to be trite. It was deeply felt.

SENATOR DONNELL: I appreciate it very much. I am sure it was.

SENATOR MURRAY: This is democracy in action here. SENATOR DONNELL: Yes.

(Mr. Linder summarized his analysis of the items which he quoted from the American Bar Association report.)

MR. LINDER: Any physician who does not wish to treat patients under the insurance system may continue his private practice; and private practice may also be combined with practice under the system. This choice remains unimpaired. When an insured person is refused by a physician he has the right to make another choice and, of course, subject to routine regulations, will have the right to change physicians.

SENATOR DONNELL: Who makes those "routine regulations" subject to which he has right to change? MR. LINDER: I should say the local area doctors, subject to the decision of the Surgeon General, and his regulations must be reasonable.

SENATOR DONNELL: But the right to change physicians is, as you say, subject to regulations made by these authorities? MR. LINDER: Of course. Senator, there are people who are crazy who run from one doctor to another. If a patient ran from one doctor to fifteen and you were the Surgeon General and you imposed a regulation that a patient could not see more than twenty doctors for the same ailment within two days, you would not think that was bureaucratic regimentation.

SENATOR DONNELL: May I ask the witness, Mr. Chairman, who does he think is best qualified to determine whether or not a change shall be made, the Surgeon General in Washington or William Smith in Sedalia, Mo.? MR. LINDER: William Smith.

SENATOR DONNELL: William Smith does not think he is crazy. Maybe he is, but he wants to change, but in order to make the change he is subject to routine regulations made by the doctors which must come to Washington for approval, so that the ultimate power is in the Surgeon General here to determine whether William Smith can or cannot go across the street to get another doctor. MR. LINDER: I say that you cannot assume an unreasonable regulation and then beat the act with that. You must assume a reasonable regulation.

(Mr. Linder completed his testimony with a further attack on the American Bar Association report and discussed at length with Senator Donnell the right to go to the courts over differences in the regulations under the proposed act.)

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SENATOR DONNELL: How old an organization is the National Lawyers Guild? MR. LINDER: About ten years.

SENATOR DONNELL: As you doubtless know, the American Bar Association has been in existence since 1878, I believe, having been formed in New York State at Saratoga Springs in or about 1878; do you know that? MR. LINDER: I have no knowledge of that.

SENATOR DONNELL: You do know that the American Bar Association has been in existence for many years preceding the organization of the National Lawyers Guild? MR. LINDER: It has all of the benefits and merits and disadvantages of age.

SENATOR DONNELL: Mr. Linder, the Lawyers Guild has approximately how many members? MR. LINDER: Approximately 3,000.

SENATOR DONNELL: So that it is somewhat less than a tenth of the membership of the American Bar Association as it was mentioned by Mr. Martin this morning? MR. LINDER: I have no knowledge of the membership of the American Bar Association and therefore cannot compare them.

SENATOR DONNELL: Has there been any feeling of hostility on the part of National Lawyers Guild toward the American Bar Association? MR. LINDER: The organizations, as corporate entities, have no hostility to each other whatsoever.

SENATOR DONNELL: As distinguished from corporate entities I am referring now to the actual physical entities; has there not been considerable feeling of hostility on the part of the National Lawyers Guild against the American Bar Association? MR. LINDER: There is a difference of opinon between them on some subjects but not on all subjects. I should think that on many subjects dealing with technical matters of jurisprudence the American Bar Association and the National Lawyers Guild may very well see eye to eye.

SENATOR DONNELL: Mr. Linder, in a very recent issue of *PM* there appears an article, very interesting indeed, in regard to Mr. Robert Walker Kenny. He is the gentleman who is the president of the National Lawyers Guild, is he not? MR. LINDER: Yes, sir.

SENATOR DONNELL: In the course of this article appears this statement to which I call your attention: "Kenny's story of his handling of the Lawyers Guild storm went like this: 'The boys just made the mistake of allowing a few scrappy individuals to sidetrack them into debating their individual political philosophies. I had been one of the founding fathers of the organization. It seemed worth sticking through a little trouble. We were to the American Bar Association as the C. I. O. is to the American Federation of Labor. The American Bar Association, which pretended to speak for the lawyers of the country, was supporting the Liberty League trying to bust the Roosevelt social program, butcher the Child Labor Law. It was a moribund, decadent outfit. I believe in keeping alive in your times.'" Does that express the general feeling, so far as you have observed, of the officials of the Lawyers Guild with respect to the American Bar Association? MR. LINDER: I should not be able to characterize the general feeling of any large body of men who differ in their views, but without desiring to avoid your question at all I should say that I personally have very strong views with respect to it and I will be very glad to state my own views.

SENATOR DONNELL: Would you state them? MR. LINDER: Surely. I believe that the American Bar Association is dominated by lawyers who represent large corporate interests in this country and who reflect the views of the largest corporate interests in our country. As far as there are reactionary, antiprogressive elements in industry, I think that the American Bar Association is dominated by lawyers who express that point of view. I think that it is not accidental at all that the American Bar Association should echo so completely the views of the organized hierarchy that dominates American medicine in the American Medical Association, and I think it is no accident at all that the Lawyers Guild should emerge as the champion of the people's rights and needs in opposition to the American Bar Association.

SENATOR DONNELL: Now, Mr. Linder, I observe in what I read, as quoted from Mr. Kenny, the statement referring to the American Bar Association, that it was a moribund, decadent outfit. I have had the word "moribund" looked up in the dictionary and I find it means "on the point of dying." Do you concur in that view with respect to the American Bar Association? MR. LINDER: I have no knowledge of whether it is dying or is not dying. I have only a knowledge as to whether it should die.

SENATOR DONNELL: And you think it should; is that right? MR. LINDER: No.

SENATOR DONNELL: What did you mean by that statement? MR. LINDER: My view is that American Bar Association is dominated by reactionary men and that—

SENATOR DONNELL: What did you mean about whether it should die? MR. LINDER: As an organization dominated, it seems to me that it ill serves the welfare of our country.

SENATOR DONNELL: Therefore, if it ill serves the welfare of our American country, it ought to die, is that your view? MR. LINDER: That is right.

SENATOR DONNELL: As regards whether it is dying, however, I recall to your memory the testimony of Mr. Martin this morning that the membership is 35,000, which he stated is the largest in the history of the organization. I refer also to this quotation from page 141 of the proceedings of the American Bar Association, volume 69, 1944:

"President Henderson," who, I may say, is president Joseph Henderson, a well known lawyer of Philadelphia, continuing the quotation—"in his statement to the house first expressed his appreciation to the staff and the official family as well as the general membership of the association for their cooperation.

He reported that the membership as of September 1 was approximately 32,564, which exceeds by 1,000 the highest previous total, which occurred in 1939."

You would not consider, in fact, regardless of your own views as to the merits of the American Bar Association, that in view of these figures and the further increase from the 32,564 mentioned by President Henderson in 1944, up to 35,000 testified to by Mr. Martin, you would not consider that in fact that the American Bar Association, to adopt the language assigned to Mr. Kenny, is a moribund organization, to wit, on the point of dying, would you? MR. LINDER: Well, an organization may be moribund and have all of the trappings and all of the outward appearances of great life. There is more than one person who has a cancer that will kill him who is walking around with all of the appearances of good health.

SENATOR DONNELL: The National Lawyers Guild, which, I take it, has the views pretty largely as expressed by you in regard to the American Bar Association, has been formed within the last ten years and contains about 3,000 lawyers. Those are facts, are they not? MR. LINDER: Well, some of them. You have put a number of things together in one question. Some of them I know something about. Some of them I do not. I do not know anything about the membership of the American Bar Association, and I do not presume to speak for what the whole membership of the National Lawyers Guild believe.

SENATOR DONNELL: You are here on behalf of the Lawyers Guild? MR. LINDER: I am here on behalf of the National Lawyers Guild.

SENATOR DONNELL: In connection with the bill? MR. LINDER: To present a report. The report I presented has been carefully studied by a committee and then reviewed carefully by a national body.

SENATOR DONNELL: Now, you said, Mr. Linder, this morning, as I recall, that approximately one third of the population receives no medical care, is that correct? MR. LINDER: I said that there is a government publication which says so.

SENATOR DONNELL: What is that government publication? MR. LINDER: I gave that to you this morning.

SENATOR DONNELL: I want to be sure that I exactly know what that is. MR. LINDER: I will be glad to give it to you again. "The Report of the Technical Committee on Medical Care," transmitted to Congress by the President on Jan. 23, 1939, House of Representatives document 120.

SENATOR DONNELL: Was that based on studies of the Committee on the Costs of Medical Care made in 1929, 1930 and 1931, and on the national health survey made in 1935? MR. LINDER: I believe so, but I have not got the document before me and I do not really recall.

SENATOR DONNELL: Now, Mr. Linder, you referred to the constitutionality of this bill, and you mentioned particularly the Helvering versus Davis case, and the Stewart case, both appearing in 301 U. S. Supreme Court, and both referring to the Social Security legislation? MR. LINDER: Right.

SENATOR DONNELL: Would you state, please, whether or not it is, in your opinion, a correct statement of law that the federal government possesses only those powers which are either expressly or by necessary implication conferred on it by the Constitution of the United States? MR. LINDER: That is correct.

SENATOR DONNELL: Will you tell us, please, what provision or provisions of the Constitution of the United States, in your opinion, authorize and confer on the Congress the power to enact legislation providing for compulsory health insurance? MR. LINDER: Section 8 of article I.

SENATOR DONNELL: Is that the "general welfare" clause? MR. LINDER: That is right.

SENATOR DONNELL: Is there any other section that authorizes it? MR. LINDER: That is enough.

SENATOR DONNELL: Is that the only one? MR. LINDER: I am not prepared to say whether it is the only one. I think it is sufficient.

SENATOR DONNELL: It is the only one to which your mind now reverts? MR. LINDER: That is correct.

SENATOR DONNELL: And that section reads: "1. The Congress shall have power: "To lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States." Is that correct? MR. LINDER: Yes, sir.

SENATOR DONNELL: There is also mention of general welfare in the Preamble to the Constitution of the United States; is there not? MR. LINDER: Yes, sir.

SENATOR DONNELL: Namely, that "We, the people of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquillity, provide for the common defense, promote the general welfare and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America." That is correct, is it not? MR. LINDER: Correct.

SENATOR DONNELL: Now, the language "promote the general welfare" in the preamble has, however, has it not, been expressly held by the Supreme Court of the United States not to confer any legislative power whatsoever; we agree on that as lawyers, do we not? MR. LINDER: No, no. The general welfare clause expressly—

SENATOR DONNELL: I am talking about the preamble, only the Preamble. The mention of the general promotion of general welfare, has it not been held by the Supreme Court, expressly in at least 1, possibly 2 cases—MR. LINDER: I believe so.

SENATOR DONNELL: —that no legislative power is conferred by the Preamble? MR. LINDER: I believe so.

SENATOR DONNELL: I believe that is correct. As to section 8 of article I of the Constitution, namely the so-called "general welfare clause," which starts as I have indicated, with the language "To lay and collect taxes, duties, imposts and excises to pay the debts," and so forth, I will ask you to state, please, whether or not you have observed that the Supreme Court of the United States has held expressly that said clause does not grant two powers; namely, the power on the one hand to lay and collect taxes, duties, imposts and excises and, on the other hand, to provide for the general welfare of the United States, has it not been held by the Supreme Court in express language almost what I am going to say, that the power conferred by this section of article I is merely a power to lay and collect taxes, duties, imposts and excises, and that the mention of the general welfare is a definition of the purpose? MR. LINDER: Is a qualification of the other.

SENATOR DONNELL: That is correct. It is a definition of the purposes for which taxes, duties, imposts and excises may be made, that is correct? MR. LINDER: It is so broad a qualification I could not really regard it as a qualification. It is the objective. I think it is correct to say that the language states the objective to be accomplished by the laying of the imposts, et cetera.

SENATOR DONNELL: In other words, the point I am making is that the Supreme Court has indicated very clearly, has it not, that there is no general power conferred by the Constitution of the United States by section 8 of article I to provide for the general welfare except so far as that provision is based under the power and dependent on the power to lay and collect taxes, duties, imports, et cetera; that is correct, is it not? MR. LINDER: I believe so.

SENATOR DONNELL: In other words, has not the Supreme Court of the United States held, in substance, that the power that is conferred is one to lay and collect taxes, and so forth, and that there is no separate second power granted by this section to provide for the general welfare? MR. LINDER: That is correct, but you must bear in mind that Mr. Justice Cardoza uses this language on page 640 of the Helvering decision: "Congress may spend money in aid of the general welfare," Constitution, article I, section 8. And I think that I cannot cite any greater authority for what the Constitution provides Congress may do than that sentence, so that the Supreme Court often has said that Congress may spend money in aid of the general welfare, and the Supreme Court has also said that Congress decides what serves the general welfare, and Mr. Justice Cardoza said "When a contention comes here," that is, a contention of unreasonableness or exercise of this power in an arbitrary fashion, "we naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to Congress." So that the burden is on him who asserts that this, the expenditure, involved is not in aid of the general welfare to show that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted.

SENATOR DONNELL: Mr. Linder, you have gone somewhat beyond the point to which I was addressing myself. The point that I was addressing myself to was, namely, that the Supreme Court of the United States has held that there is no general power to provide for the general welfare created

by section 8 of article I, that the reference to general welfare is solely as definitive of the purposes for which taxes, duties, imposts and excises may be laid and collected. MR. LINDER: That is clear.

SENATOR DONNELL: And the power to spend money as pointed out by Mr. Justice Cardoza has been indicated by the Supreme Court to arise as a necessary incident of the power to lay and collect taxes; in other words, if Congress has the power to collect, inferentially, there is an implied power to spend money which it has laid and collected the taxes to secure it. That is correct, is it not? MR. LINDER: Correct.

MR. LINDER: I should like to make clear my personal view with respect to the American Bar Association. If anything that I have said here indicates any personal hostility to the organization, as such, I regret it. I regard the American Bar Association as an organization of lawyers. Many lawyers who belong to the American Bar Association are my friends and are well known to me both professionally and otherwise. I think the American Bar Association, as far as it deals with technical matters, dealing with subjects within the realm of civil and criminal jurisdiction, contributes, takes positions that are frequently taken by the National Lawyers Guild. However, in the tremendously important field of social legislation, in all of those with respect to that whole body of legislative matter which so directly affects the interests of the people of the United States, I think it is true that during the last ten years, at least, the American Bar Association has consistently taken a view which, in the opinion of the National Lawyers Guild, is a view not in the interests of the people of this country.

The American Bar Association has regarded the Social Security Act as unconstitutional. Its representative here this morning appeared before the United States Supreme Court and argued the unconstitutionality of that statute. Not persuaded by the United States Supreme Court and unmindful of the fact that that decision is binding upon him, he still continues his assertions about the constitutionality.

The American Bar Association, in connection with this specific legislation, I think, has taken a position which serves the interests of the people of our country very badly.

In echoing the position of the American Medical Association, the American Bar Association, I think, has taken a very unfortunate position and it is a matter of some regret to me that they have done so.

I think in taking that position, however, the American Bar Association does not bespeak the views of the overwhelming majority of the lawyers in this country.

APRIL 9, 1946

HONORABLE JAMES E. MURRAY Presiding

PRESENT: Senators Murray, Wagner, Ellender, Aiken and Donnell.

Statement of Fiorello H. La Guardia, Former President of U. S. Conference of Mayors

MR. LA GUARDIA: I take it that there is little opposition to the provisions in the early part of the bill on maternal and child health, on the contributions and federal grants for tuberculosis and venereal disease. Your authorization for appropriations is extremely low. I have spent a great deal of money during the past twelve years and I am very proud of what we accomplished in New York City and the program which I left for my successor.

Now we come to the health insurance. Tuberculosis can be licked in this country in twenty-five years if we have proper controls as provided in this bill. The medical side is not enough, you must also have proper housing, proper nourishment in the prenatal stages and in infancy and childhood and proper ventilation and sanitation, and then we will lick tuberculosis.

(Mr. La Guardia described construction of medical facilities in New York under his administration.)

You will find that when you get your maternal care provisions of this bill in operation you will then realize how woefully short this country is of proper maternal care. You will have to build hundreds and hundreds of lying-in hospitals, and it will take you some time to get the necessary personnel to man these hospitals.

A major disease, a major operation or a serious disease will throw a family budget out of gear for a year or a year and a half, and the family is compelled to borrow, and then they get into a worse disease, and that is the loan sharks. And that is another fit. Do not get me started on that because I never stop.

There is nothing new in this plan, it is just pooling the health of the country, that is all there is to it. We pool our health so that the sick, regardless of economic conditions, can get proper care when it is needed. And in five years, gentlemen, if this plan is operated properly, you will be able to reduce your hospital cases and sickness by 50 per cent, and that is no exaggeration.

I am not worried at all about the cost. No matter what the cost is, it is a good investment. Your operating costs will be greater the first five years and then will diminish. If you have the money on the table at this moment and say that you are going to start this plan all over the country on July 1, you cannot do it. It will take time to get this going in the entire country, and it is of great importance that it starts right, and if it starts right it will be perfected and it will click. If it starts wrong, it will take a generation to correct the mistakes.

There has been a great deal said that this would regiment the medical profession. It will not regiment them at all, but it will certainly give an opportunity for the skilful doctor, the studious scholarly physician, that keeps abreast, to develop and grow and to practice his profession. No one contemplates for a moment that skill should not be recognized. Under our plan in New York City we estimate paying some salaries of $25,000 or $30,000, and here is the opportunity for the young graduates of medical schools to have a chance of really getting a start, and in many sections of our country they have no such opportunity.

We are limited in our capacity, in our hospitals, for interns and in smaller communities the young graduate just has to grope his way along. This would provide a constant twenty-four hour medical service, emergency cases would be cared for by the younger doctors, who would immediately call for help if they found a serious case, and provide for office treatment, in the offices of the doctors, and provide for home treatment and for the complete hospitalization, including nursing.

. . . . . .

(Under questioning by Senators Ellender and Donnell, Mr. La Guardia said he thought a plan could be started only in a limited area.)

SENATOR DONNELL: So that you are recommending an addition to title II. In other words, as I understand your testimony, while it is a nationwide operation, you would defer the benefits of that operation to any given area until the area shall have provided necessary facilities to enable the operation to be successful, is that your thought? MR. LA GUARDIA: Until the administration can get the doctors in there.

SENATOR DONNELL: Under the nationwide administration? MR. LA GUARDIA: Your administration is provided for here, and that is quite all right.

SENATOR DONNELL: Which section is it that you are referring to, Mr. La Guardia? MR. LA GUARDIA: I am referring to the whole thing. I want to point out that, if this was to go into effect on July 1, in many sections of our country we could not provide proper medical care.

SENATOR DONNELL: In other words, you would not then institute a nationwide prepaid personal health service benefit at this time; you would require, as I understand it, that each state, or each area, perhaps better stated, shall have first demonstrated its capacity to take care of the problems before you would impose the tax in that area; is that right? MR. LA GUARDIA: I would establish a national system, and I would put it into operation and make the charge wherever there is personnel and facilities to give the service, because it would be manifestly unfair, the charge being uniform, not to provide uniform first class services for the same cost.

SENATOR DONNELL: That would necessitate a very different bill from what we have before us here in order to put into effect your suggestion, would it not? MR. LA GUARDIA: Not at all.

SENATOR DONNELL: There is nothing in title II that undertakes to say that this nationwide prepaid personal health service benefit shall go into effect only piecemeal here and there throughout the United States, is there? MR. LA GUARDIA: I would put it in.

SENATOR DONNELL: What would you provide there in substance? MR. LA GUARDIA: I would provide that the Surgeon General may establish health insurance zones, and, as such zones are established, people resident therein shall be entitled to the benefits herein provided, and the Surgeon General shall provide as rapidly as possible proper medical facilities and

hospitals, as well as personnel, in all areas, and when such areas have been certified by the Surgeon General they shall become eligible under the plan.

SENATOR DONNELL: You would not assess a payroll tax then in area number one, for illustration, until the benefits of the bill shall have been put into effect with respect to area number one? MR. LA GUARDIA: That is right.

SENATOR DONNELL: Now, Mr. La Guardia, that is a very interesting suggestion, and I am sure our committee is glad to have it, but to my mind it would necessitate a tremendous change in title II of this bill, because this is a nationwide proposition encompassing and envisaging, as I understand it, an assessment of some kind of a tax, nationwide, rather than starting up a tax in Missouri and Oklahoma and Kansas one week and waiting six months before you put the federal tax into effect in three other states. MR. LA GUARDIA: You would not put the federal tax unless they were getting the service.

SENATOR DONNELL: Well, Mr. La Guardia, do you think it would stand the test of the uniformity of taxation throughout the nation to impose a federal tax in two or three states and then wait six months before you imposed a federal tax in two or three other states? MR. LA GUARDIA: Certainly, people in my city drink French champagne and they pay the tax on that, and the people in Iowa do not drink the champagne, and they do not pay any of that tax.

. . . . . .

(After Senator Donnell caused Mr. La Guardia to explain still further his idea of taking in part of the country at separate times, Mr. La Guardia described still further the New York City facilities.)

SENATOR ELLENDER: Now, in addition to the hospitals to take care of the sick, can you not also see the necessity for educating more doctors? MR. LA GUARDIA: I have stressed that.

SENATOR ELLENDER: How would you do that? MR. LA GUARDIA: With these hospitals. You cannot educate doctors unless you have hospitals.

SENATOR ELLENDER: How would you provide for that? Would you say that the Congress ought to provide means by which doctors are to be educated? MR. LA GUARDIA: Senator there are 25,000 able, competent young students in this country today that cannot get into medical schools because we have not the facilities. That is no exaggeration.

SENATOR ELLENDER: Would you provide for the education through federal means or federal funds? MR. LA GUARDIA: No, they would take care of themselves.

SENATOR ELLENDER: They do? MR. LA GUARDIA: Yes, we had no trouble getting students. The trouble is in facilities. You see, a medical school is not like a law school. A law school you just jam them in, and you throw them in, and they listen sometimes and sometimes they do not listen, and it makes no difference. But in a medical school you have to have the facilities and you have to have your dissecting rooms, and you have to have your labs, and you have to have the facilities and they are limited in number.

SENATOR ELLENDER: Would you provide for any funds in order to help them in their education? MR. LA GUARDIA: No, the hospitals will do that. I am not exaggerating when I say that there are from 20,000 to 25,000 young students trying to go into medical schools and cannot get in.

SENATOR ELLENDER: What incentive would there be to those young doctors who propose to take up medicine when they would be confronted with a proposition whereby they would have to join an organization or say they would have to qualify before being employed or their fees would be fixed? MR. LA GUARDIA: I think the same incentive that you and I had when we went to law school; we would go to Congress some day.

SENATOR ELLENDER: I know, but the thing is, you would have a board here in Washington, fixing a set of fees applicable in various areas of the country, by which a doctor would have to abide. MR. LA GUARDIA: He would make a nice living and render fine services.

SENATOR ELLENDER: And, of course, it might lead to being put on a salary basis. MR. LA GUARDIA: It is better to be on a salary basis than have fees and be unable to collect them.

SENATOR ELLENDER: You still think that you can get young men? MR. LA GUARDIA: Certainly.

SENATOR MURRAY: There are a great many young doctors today that are unable to exercise their profession because they cannot get any place where they can get business. If they go to the backward sections of the country they cannot live.

MR. LA GUARDIA: Those people are really martyrs, doctors in this country; there are thousands of them who are just rendering a community service and eking out an existence. Why, old man Dafoe told me he never made over $300 a year until Mrs. Dafoe came along and then he was living in clover, and he got the allowance from the Dominion of $1,800 and he used to come down to my town to celebrate. He was a great old man.

SENATOR MURRAY: The establishment of this system would result in greatly increased incomes for the average medical practitioner. MR. LA GUARDIA: And for the average American family too in savings. The only ones who will suffer are the loan sharks and the undertakers. It will be tough on them.

(Here there was some discussion of state's rights. Mr. La Guardia tried to show that only American Medical Association officials opposed the bill. Under insistence by Senator Donnell he finally said:)

SENATOR DONNELL: But the point I am making is that the American Medical Association, which as I understand it is the largest association of physicians in the country, has expressed itself in opposition to compulsory health insurance, has it not? MR. LA GUARDIA: As an organization, yes.

. . . . . .

SENATOR DONNELL: The point I was getting at was this: If in a small community, like the one in which I live, a suburb of one of the Midwestern cities, if I desired to consult with a given doctor, say, Dr. Jones, and his quota is made up, he has 500 patients allotted to him and I am 501 or 502, I cannot receive his services? MR. LA GUARDIA: He can drop some one else, can he not?

SENATOR DONNELL: I am not sure about that. MR. LA GUARDIA: Suppose Dr. Jones has just 1 patient. You come along, and he can say "I don't want you."

SENATOR DONNELL: He can do that of course; but if he and I are willing there is nothing to prevent that from existing under the present law existing today, at this minute. Mr. LA GUARDIA: No.

SENATOR DONNELL: But if this law goes into effect and he does have his quota of 500, and he is satisfied with his quota, and I come along and want to get in myself there is no way I can engage him without having him drop some one off his quota? MR. LA GUARDIA: I think that is an extreme determination, Senator.

SENATOR DONNELL: It is true, is it not? MR. LA GUARDIA: Yes.

(Mr. La Guardia, aided by Senator Murray, defended the thesis that it made little difference to the patient to have individual choice of a surgeon.)

Statement of Joseph W. Fichter, Chairman, Joint Subcommittee on Health of the National Planning Association

MR. FICHTER: I am master of the Ohio State Grange and chairman of the Committee on Health of the National Grange. Since I am appearing before you as chairman of the National Planning Association subcommittee, it may be useful to those of you who may not be entirely familiar with National Planning Association's background to have a brief explanation of its approaches to the study of national problems.

National Planning Association is a nonprofit, nonpolitical organization established in 1934. For the past several years NPA's work has been carried out mainly by four standing committees: three on National Policy—the Agriculture, Business and Labor committees; and one on International Policy, which weighs the international implications of the problems under consideration by the Committees on National Policy. I have here a leaflet, which I will be glad to submit to you, which includes the names of NPA's board and committee members.

The Joint Subcommittee on Health—for which I am speaking this morning—was set up by the Committees on National Policy in 1945 and includes members from each of those committees. Incidentally, I serve regularly as a member of the Agriculture Committee.

First we investigated the cost of a campaign to wipe out tuberculosis and compared this with the costs of going on with this disease year after year, as we do now. Second, we examined the cost of building enough new hospitals to provide beds for all who need hospital care and the amount of materials and manpower required to build them.

(He described eradication of tuberculosis in cattle.)

(After discussing various projects for control of tuberculosis in human beings, Mr. Fichter said:)

MR. FICHTER: If we add up all these amounts we find that a total of about $186,850,000 public and private funds was spent on this disease in 1943; and because this was a war year practically no construction of new hospital beds was undertaken. Yet this very large sum which is spent on tuberculosis annually takes no account of the personal income lost to families which occurs when wage earners die or are disabled by this disease or of the output of goods and services lost to the nation from this cause. Such losses are especially important in the case of tuberculosis, since this disease tends to strike men and women during the most productive period of their lives—between the ages of 20 and 45.

One year's deaths and illness from tuberculosis caused a loss in potential wages for that year alone of over $181,627,000. Faced with an annual expenditure of $186,850,000 and an annual wage loss of $181,627,000, it would certainly seem worth while if for economic reasons alone to try to eliminate tuberculosis.

(He described the technic for stamping out tuberculosis.)

With such facts as these in mind we tried to estimate the cost of carrying out a campaign to rid the United States of tuberculosis in the next ten years. We began with the problem of finding the cases. Children under 5 should be given tuberculin tests, which could be done by their own doctors as a part of their routine examinations. They need x-rays only if these tests prove positive. Older children can be x-rayed on entrance to school and, if found negative, need not be examined again until they are 15. The new cost would be the examination of the adult population.

It would be feasible to examine the entire population above 15 years of age in the United States in the course of five years. Taking this population in 1943, we find that it would require 102,508,000 x-rays to examine it once, or about 20.5 million x-rays a year. Of course, one examination would not be enough and the procedure should be repeated in the second five years. In addition we would follow up "the contacts"—people who had been in closest contact with those found to have tuberculosis—and probably should x-ray them every six months. If all those ill with tuberculosis were treated in sanatoriums during this period, so that the disease was not being communicated to others, we should have reduced the disease to such negligible proportions by the end of the ten years that only occasional testing would be necessary and, of course, testing for people who came into this country after they have been in other countries.

The new technics of mass x-raying have greatly reduced the costs of such examinations. At a cost of 25 cents a case the 20.5 million x-rays would cost about 5.1 million dollars. And this yearly cost would continue throughout the ten years of the campaign.

How many people would be needed to carry out this undertaking? It has been found that a unit consisting of one medical officer, one technician and one clerk can efficiently take 1,000 pictures a week, or 50,000 a year. It would require at least 410 such units to examine the 20.5 million people each year of the campaign, because each unit cannot work at peak efficiency in sparsely settled areas.

The cost of following up "the contacts"—the group in the population most in danger of breaking down with the disease—is estimated to be about $1,800,000 a year for the first five years of the campaign, but thereafter it would diminish. This figure is based on an average of three contacts for every case of tuberculosis found and a cost of around $10 a year for follow-up work on each contact.

It does little good to find cases if we cannot provide places for them to receive treatment where they will not infect their families or neighbors. We would have to provide new tuberculosis beds for the new cases found, but this would be a nonrecurring cost and the task should properly be undertaken before the mass x-rays are started, so we will discuss this construction cost a little later.

Assuming that we have enough beds to permit all who needed them to have one, what would it cost to maintain the patients in those beds throughout a year? According to our estimates, we would probably have about 133,000 patients in hospitals for tuberculosis in the early years of the campaign. After that there would be a considerable reduction. Using a 1943 cost of $3.50 per patient day, the maintenance cost would be about $173,000,000 for a peak year.

We found that we would need, to care properly for this number of patients, approximately 47,900 professional personnel: 3,000 physicians, 27,800 nurses, 4,600 technicians, 9,200 clerks and 3,000 others. About 6,900 attendants and orderlies would be needed, and about 30,900 domestic workers.

We should also have to spend a large sum on health education, because people would need to understand the value of the examinations and treatment, the need for continuing treatment until they were really well and the care needed to avoid infecting others with the disease. Probably we should have to spend about $12,000,000 a year on such work, at least during the first years of the campaign.

The provision of rehabilitation services for patients with tuberculosis is another essential of the campaign. Such services are those necessary to render a patient fit to engage in a normal economic and social life. Because tuberculosis is a chronic relapsing disease, patients have to avoid overexertion even after their cases are arrested and apparently cured. It is often necessary for the patient to learn a new way to earn his living, and this is especially true if his former occupation involved excessive physical exertion. If we fail to keep the tuberculous person permanently well we waste the funds spent on finding him and on medical care and hospitalization.

Instruction for those who need further education and vocational guidance and training should be available for all people in sanatoriums who could profit by them as soon as the physician has said that it is medically safe for the patient to start some activity. Librarians, occupational therapists, vocational counselors and medical social workers are needed for this work in addition to teachers. In the peak years of the campaign when all the beds were being used, an adequate rehabilitation program might cost $20,000,000.

Financial assistance to families in which the wage earner has tuberculosis is a necessary part of the campaign. Many a patient refuses to go to a hospital when he is first told of his condition because he is worried as to how his family will manage. Instead, he continues to work until the far advanced stage of the disease forces him to bed, and by then medical care can do little for him. Or he accepts bed rest in a sanatorium until he feels stronger and leaves before he is well, to earn more money for his family. After a few months of work he often breaks down again with an advanced stage of the disease. Also he may have been spreading tuberculosis among his children and his fellow workers.

Financial assistance under the three public assistance titles of the Social Security Act may give some help to the family of the tuberculous patient. For example, aid to dependent children provides assistance to families when incapacity prevents a parent from supporting the children. Payments under this program are financed by state and federal funds and vary among the states. In May 1945 monthly payments ranged from an average of about $21 to $89 per family. Unless the family has other resources, these amounts are not adequate for today's living costs. Dr. L. I. Dublin of the Metropolitan Life Insurance Company suggests that $1,500 might be the average annual compensation for such a family. Allowing $1,500 for families who needed it, the cost would be about $57,000,000 in the peak years of the campaign. This is based on an assumption that about 80 per cent of the tuberculous male heads of families would have had incomes of less than $5,000 and hence would not have enough savings to tide them over a year or more without earnings.

The last of the recurring items of expense in the campaign years would be for medical research. Probably $3,000,000 a year should be available until satisfactory results are obtained in the search for a drug that would kill the bacillus, especially in view of the rapid travel that will bring people into contact with the disease in other parts of the world. When we add all these expenditures, we find that it would cost about $309,900,000 annually for recurring items in the peak years of the campaign.

However, we must also consider the cost of construction of the necessary tuberculosis beds. These should be started before the mass x-rays are begun and should be completed in the first year of the campaign, as the patients found must have places to go for adequate treatment. Although this would mean a large initial expenditure, the elimination of the disease would release the beds for use for other chronic diseases or for homes for convalescents and the aged. Accordingly, as part of an adequate hospital construction program, the new hospitals for tuberculosis or new tuberculosis additions to other hospitals should be so located and built that they would be suitable with the least alteration possible for these other hospital purposes. The real value of these facilities at the time they were turned over to other uses could then be deducted from the total cost of the tuberculosis campaign.

It is estimated that we would need about 154,000 plus tuberculosis beds in the first years of the campaign. Since there are about 79,000 adequate beds now in existence, we should build 75,550 new beds. Although we recognize that present costs of building these beds would be at least $7,000 a bed, we have made our analysis in terms of 1943 prices as we have done in the rest of the study. Figured in this way the beds

would cost $5,000 each, or a total of $377,000,000 plus, which would include the cost of construction and equipment.

The value of these beds at the end of the ten year period would be about $309,000,000 plus, assuming a straight line depreciation and a life of fifty years for the facilities. Accordingly, it may be said that only $67,995,000 of the costs of the hospitals should be assigned to tuberculosis.

To sum up, expenditures during a peak year of the campaign to eliminate tuberculosis would be about $309,900,000, and they would decrease as the campaign progressed and virtually cease at the end of ten years. In addition, about $68,000,000 could be charged to the campaign as the cost of tuberculosis hospital construction. We can see that this is not an extravagant campaign when we compare it with the $186,850,000 now being spent annually on this disease and when we remember that tuberculosis causes a loss of wages and of production.

THE HOSPITAL PROGRAM

The suggested plan, which has been described by the United States Public Health Service, would require a careful analysis of the hospital needs of each state and of areas within the state as related to distribution of population. It would aim to extend facilities and service to all persons regardless of geographic location in such a manner that some health facility would be available within a reasonable distance of every home in the state. The plan assumes that financial barriers would not keep patients from using the hospital services when needed; its effectiveness would depend on the degree to which this was possible.

The different facilities in the plan would be coordinated so that each unit would act as one part of total community health. In order to avoid unnecessary expense and duplication of equipment and personnel, only limited facilities would be contemplated in outlying districts, with the understanding that, where necessary, patients would be referred to larger and more central institutions. Large base hospitals could thus serve a broad region. Existing hospitals could make arrangements to fit into the integrated system according to the types of service which they are able to perform.

To equip the United States with sufficient facilities to make this plan effective, it was estimated that it would be necessary to build 231,000 general, 75,550 tuberculosis and 212,556 nervous and mental hospital beds, or 519,000 beds of all types. Of these 340,000 would be new and 179,000 would be replacement beds. These estimates were taken from the testimony of Dr. Parran, the Surgeon General of the Public Health Service, before the Senate Committee on Education and Labor in hearings on Senate Bill 191 in 1945. This estimate does not include the beds which might be needed for long chronic diseases, nor does it include the plans of the Veterans Administration.

Using 1943 prices, we found that construction and equipment of these beds would cost about $2,600,000,000 plus. We assumed a cost per bed of $6,000 for the general bed, $5,000 for the tuberculosis bed and $4,000 for the nervous and mental bed. We realize that present construction costs are considerably higher but, to keep our estimate throughout the report comparable, we have had to use the year 1943.

Under this plan it would also be necessary to build about 14,000 health centers at prices ranging from $35,000 to $75,000 a center. These centers would be equipped to diagnose and to treat ambulatory patients and to perform the more traditional health department services. In communities which lack other medical facilities, the health centers might also include some hospital beds for emergency cases. The total construction and equipment cost of those centers would be about $679,765,000.

This, the total cost of building and equipping hospital beds and health centers, would be approximately $3,000,000,000 plus. Carrying out such a program would have a direct effect on the construction industry and an indirect effect on many other industries. In studying this effect it is necessary to separate the construction and equipment costs.

The total construction cost of the program would be about $3,000,000,000. Information derived from Labor Department figures show that according to past experience this would mean (in 1943 prices) an expenditure of $921,000,000 plus for labor at the construction site, of $1,485,000,000 plus for materials and of $604,000,000 plus for "other" expenses and profit. Exhibit B shows the type of materials, such as electrical wiring and fixtures, forest products, iron and steel, and so on, and the values of the orders which would be placed.

Approximately 2,000,000,000 plus man hours would be created by the proposed construction program. Of these, 771,000,000 plus would be at the construction site and 1,310,000,000 plus would be in mines, forests, factories, transportation and administration.

Statement of Helen Hall, Director, Henry Street Settlement, Appearing for National Federation of Settlements

MISS HALL: There are those who will tell you to go slow in setting up the "Nationwide System of Prepaid Personal Health Service Benefits" projected in section II of the National Health Bill (S. 1606). That section means health insurance, and in supporting it I am reaffirming a stand which our National Federation of Settlements took as early as 1917.

To argue for delay is only too often a shabby device to defeat some progressive move that can't be downed on its merits.

It would be out of the question for any one to live as we do in industrial neighborhoods without recognizing that it is high time for working people to be protected against a double hazard—against sickness compounded with loss of wages. That is why settlement workers have so long been concerned about it. Year after year it has been driven home to us what the lack of such protection can and does do to family life.

Over the years we have seen opposition to an American system of health insurance—built up around false assumptions, at least so they seem to us. One of these assumptions hinges on an unwillingness to face the actual lack of adequate medical care among millions of American families.

Another false assumption has been that prepaid medical care —such as this bill proposes—must necessarily be bad. That contention was used in the 1930's when health insurance was struck out of Franklin Roosevelt's initial program for social security.

SENATOR DONNELL: Miss Hall, who do you mean it was who struck out that health insurance from this program? MISS HALL: The opponents of it.

SENATOR DONNELL: Was there a measure pending? MISS HALL: I sat on the President's Advisory Committee on Social Security, and in the early days there was then a plan for health insurance in the bill and the opposition was so great that it was taken out.

SENATOR DONNELL: Was the bill on the floor of Congress when the provision for health insurance was taken out or was it taken out preceding the introduction? MISS HALL: Preceding the introduction. I presume it was taken out so that the whole bill would not be killed. The same thing had been said in the 1920's when Herbert Hoover's Committee on the Costs of Medical Care aroused nationwide discussion of comprehensive coverage for the United States. To support this contention, two rusty clichés are repeated over and over again. One is that the doctor-patient relationship would be impaired. Another is that the free choice of physicians would be endangered. As to the doctor-patient relationship, our National Federation of Settlements in 1938 made a first hand study in twenty-three cities located in sixteen states of what their neighbors do when they are sick. This inquiry brought out that two thirds of those interviewed had no family doctor at all. Even in the case of the third that claimed to have one, the connection was often nebulous and unsustained. You cannot have a patient-doctor relationship with a doctor you can't afford to use.

Then there is the free choice of physician. Opponents of health insurance who put such stress on it often claim at the same time that outpatient clinics and hospital wards can be looked to to supply the needs of the low income sick. Yet they have to admit that there is seldom free choice of doctor and scant doctor-patient relationships of the sort they prize in either a clinic or a ward. They refuse to face the truth that both the relationship and the free choice can be counted on only in higher income-brackets than are dealt with in this bill.

To say this is no reflection on the medical profession, which probably gives more of its time and skill than any other calling. But that is no reason why, when sickness strikes otherwise self-reliant families, they should have to be dependent on medical generosity or on public and private aid at the indigent level nor why we should not all frankly recognize that as a whole these families need much more than doctors can or should give away.

It is hard to understand why the insurance principle, which is used to spread risks and to safeguard almost every other contingency of our lives, should be thought so unmanageable when applied to protecting health among people in the low income brackets or when the government has anything to do with it.

I am sorry to see only limited nursing service in the bill, because a good visiting nurse not only speeds the patient's recovery but teaches the family what to do in the other twenty-three hours of the day and night when she may not be there. It sometimes seems that the greatest differential between the

rich and the poor in time of sickness lies in the nursing care they can afford. Visiting nurses in the United States bridge that gap as they climb tenement stairs or travel around small towns or ride over the long stretches in country districts. Any one who has seen a visiting nurse come into a home and in short order make sickness seem manageable to a scared and sometimes ignorant family will know how important a part the nurse plays in the health plan.

(*Miss Hall described a number of cases in her experience indicating lack of medical care.*)

(*Miss Hall next discussed British experience.*)

SENATOR DONNELL: I observe in the course of your statement you mentioned two experiences you have had with army physicians. One shows a quite satisfactory result; namely, the one in the South Pacific; the other doctor, on a serious illness in France in World War I, which you described as some pretty casual treatment. I understand from your experience in one case it was quite satisfactory and in the other, I judge from your language, it was rather unsatisfactory. Is that correct? MISS HALL: That is right. And I would say I have had exactly the same experience with private physicians. That is what I meant to imply, that I do not think the treatment had anything to do with the fact that they were army doctors or paid by the government, but that one was good and the other was not. Exactly the same thing happens in private practice. A good doctor is a good doctor, and one that is not is not a good doctor.

(*Senator Donnell questioned Miss Hall extensively on free choice of physician.*)

SENATOR DONNELL: The question I asked you was, under the existing system today, in the absence of a statute, every doctor has the right to make his own determination as to whether he can or cannot increase the number of patients he is treating? MISS HALL: That is correct.

SENATOR DONNELL: Whereas under the bill, the Surgeon General would be the determining official who would determine whether or not the doctor could take a given person? MISS HALL: That is right.

SENATOR DONNELL: Because the Surgeon General could determine, as the act states, the maximum limits to the number of potential beneficiaries. MISS HALL: That is right.

SENATOR DONNELL: So we do have a difference between that and the present system under which the doctor uses his own judgment. The system under S. 1606 is the Surgeon General through this limits the number of potential beneficiaries, he makes that decision for each individual. MISS HALL: That is correct. I would say that the medical profession, as a whole, made the decision rather than the individual doctor, which might be preferable, and I would like to say a word on that.

SENATOR DONNELL: I would be glad to have you do it, but at that point I notice that subdivision (j) in section 205 does not say that the medical profession makes the decision but says that the Surgeon General may prescribe the maximum limits to the number of beneficiaries. MISS HALL: The Surgeon General is a doctor.

SENATOR DONNELL: But he is not the profession. MISS HALL: My understanding of the bill is that the medical decisions are made by doctors alone, by the medical profession alone.

SENATOR DONNELL: Regardless of whether that decision is by the medical profession, it may have the effect in individual cases of preventing a prospective patient from securing the doctor whom he or she would like to secure? That is correct, is it not? MISS HALL: That is correct. Senator, I would like also to say that the lack of money also puts you in the same position.

SENATOR DONNELL: That may or may not be correct. MISS HALL: That is true.

SENATOR DONNELL: I think it was pointed out in your testimony that the generosity of the physicians is well known, and many physicians have given services freely and generously even to their own great detriment. MISS HALL: But I also pointed out I did not think that could cover the whole needs of the American people and that we should not ask them to do it.

SENATOR DONNELL: That is quite true. I do not think there is any necessity in asking them to do that, but I think there is an alternative other than the federally controlled compulsory health insurance. MISS HALL: This looks good to me, anyway.

. . . . . .

MISS HALL: Senator, I do not think people in America have the choice of physician. Two thirds of them do not have a physician.

SENATOR MURRAY: And nine out of ten people in America would not know how to select a physician? MISS HALL: And one third, I have talked to them, I know these people have no choice of physician. It is really a myth.

SENATOR MURRAY: I think you are right.

MISS HALL: People talk about a choice of physician. After all, people who cannot afford a physician cannot have a physician.

SENATOR MURRAY: And many, if they tried to select a physician, they would make a mistake?

MISS HALL: Do you have any choice of a physician in a clinic? Certainly not. There is very little choice of physician in the case of people this bill applies to. Of course, there is in our case.

SENATOR MURRAY: And when they do not have the choice of a physician or the right of a choice of a physician they get adequate and effective and efficient service. I know of cases where people have traveled all across the continent of the United States to get to Johns Hopkins Hospital, and when they get there the surgeon they intended to be operated on by is either too old or sick or unable to operate, and the patient is operated on by an assistant with a very efficient operation, and it is satisfactory in every detail. That happens frequently. So I agree with you that this idea of the right to select is somewhat exaggerated at least. MISS HALL: Two thirds exaggerated.

SENATOR DONNELL: Two thirds? MISS HALL: Two thirds, in our study, Senator, have no family physician.

SENATOR DONNELL: Pardon me, Miss Hall. At any rate in the first place, what you mentioned in your testimony was unemployment insurance, was it not? I do not recall whether you mentioned workmen's compensation or not. I think you mentioned unemployment insurance. MISS HALL: That is right.

SENATOR DONNELL: And there are the differences to which I have referred between unemployment insurance and health insurance? MISS HALL: Yes, certainly. That is what I think is so sad, some of the differences.

SENATOR DONNELL: Senator Murray clearly indicated to you his doubt as to the ability of the average individual to select a physician, and as nearly as I can recall, his suggestion was that the chances are that nine times out of ten the person would not know how to select his own physician. Do you concur in that view? I did not observe your answer as indicating concurrence. MISS HALL: I do not think I have any statistics on that subject.

SENATOR DONNELL: Do you think nine people out of ten are not able to select their own physicians in this country? MISS HALL: I would not for a minute say what percentage, Senator, because I have never made a study of that thing. I would say this: that people in the working class areas are often very ill able to know which physician is best in that area for them to go to. Suddenly a child will get sick in the night, and they have not even thought of a physician before, and they run outside, over to a cousin or a neighbor, and they say "Mary is sick. Whom will we get?" And this one says "This one took care of us; you had better go down there," or "This one is on the corner. You will only have to go two blocks." That is not a very careful choice. I do not know whether you call it free choice, but it is not very important.

SENATOR DONNELL: The point I was getting at is whether or not you concur in the view—if I have correctly quoted the Senator, and if I have not, I want him to correct me—that the chances are that nine times out of ten people would not know how to select their physicians.

SENATOR MURRAY: I think I would like to correct that. I meant that nine times out of ten they would not be in a position to. People in this country change residence a great deal. They travel a great deal, especially among the workers of the nation.

I will admit that the richer class think they know how to select a physician. Certain physicians have very attractive "bedside manners" and friendly associations in society, but that does not prevail among the great masses of the American people. They very seldom know a doctor intimately. If a doctor meets them on the street they do not recognize him, do not recall him. That situation prevails broadly in the country and I think among the great masses of the American people. They are generally in a situation where they would not be able to select the doctor efficiently that they should have in an emergency or in a sudden illness. MISS HALL: That I would agree to.

(*Close questioning by Senator Donnell led Miss Hall to conclude that there would be quite a rush among patients to get first on the list of the ablest physicians.*)

SENATOR DONNELL: Now, Miss Hall, you know the organization known as the International Labour Office, do you not? MISS HALL: Yes.

SENATOR DONNELL: May I read these two sentences, which I would think are applied to Chile:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other."

Have you observed that, as the number of insured persons increases, the tendency that I have just read develops? MISS HALL: No. The point is this: The doctor does not have to take a panel patient. He can take as much private practice as he wants. If he wants to take three quarters private practice and one quarter panel, he can do it. So the panel is not forced on him by the government. If he wishes to take it he can. Maybe the system in Chile is different. I do not know; but that is the answer to that, that you can take as much private practice as you want and can choose as much panel practice as you want.

SENATOR DONNELL: If the United States should adopt a plan under which the whole employed population is brought within the scope of compulsory sickness insurance, the great majority of doctors would find themselves in the insurance medical service. MISS HALL: What I would hope is that we would have enough doctors to take care of the whole population.

SENATOR DONNELL: But we would find the tendency, with the increase of number of persons insured, that more and more doctors would devote themselves exclusively to the work of the government? MISS HALL: That would be their choice, but they do not have to.

SENATOR DONNELL: But that would be the tendency, a decided tendency, in your opinion? MISS HALL: I think that doctors do certain kinds of private practice; they probably would stay and take a few panel patients. This is the way it seems to work in England, by the way, and we have not got any other experience.

SENATOR DONNELL: May I ask you, do you agree with this statement which appears in the report of the National Labour Office, 1944:

"A national medical service is already in operation in New Zealand and in the Soviet Union, where every inhabitant is entitled to free medical attendance, drugs and hospital treatment. In the former country no change has been made in the method of furnishing medical care, which remains that of individual practice; the doctor is refunded by the state a fixed fee per visit or consultation and is not legally entitled to additional remuneration from the patient." That is National Medical Service. MISS HALL: That is not health insurance. The Russian system is that the doctors are paid by the government, but that is not what we are asking for in this bill.

SENATOR DONNELL: Let me ask you this question also. Take a religious organization, we will say. Take, for instance, the Christian scientists. I am not entirely familiar with their teachings, but I understand generally that they feel that treatment by physicians is not necessary, that they rely on their religious views to have healing, at least in large part, perhaps entirely. What is your comment, if any, with respect to a law which would impose on the people in great numbers, such as the Christian scientists, the obligation to pay taxes toward the support of a compulsory health insurance in which they would feel that it is unwise and improper that they should participate? What is your judgment on that? MISS HALL: I might say that I pay taxes in the country for schools and do not use them. I do not mean that I do not believe in schools, but I do not use the schools that I am paying taxes for. I think a great many of us pay taxes for the things that we do not use ourselves. I do not think that is a great hardship on the Christian scientists. Maybe, as the years go on, we can work something out. I would not say that was any great deterrent.

SENATOR DONNELL: Take a situation in which a great religious organization does not believe in either the efficacy of or the advisability of submitting their members to health treatment under such a law. Do you think that in fairness to them they should be subject to the obligation to contribute by taxation to the support of such a system? MISS HALL: I think a Christian science witness would do better than I would.

SENATOR DONNELL: I am asking for your opinion. MISS HALL: I have not thought about it.

SENATOR MURRAY: Let me ask a question here, please, Senator. Do you not feel that, if the American people should feel that the national health system is essential for the welfare of the whole country, there would not be anything unreasonable in seeing to it that all the people of the country contributed to the support of that kind of a system? MISS HALL: I would feel so, Senator, on the basis that many of us pay for things that are good for the country as a whole that we may not personally benefit from or even believe in.

SENATOR MURRAY: That is right. In a democracy the majority rules. If a majority of the Americans feel it is essential for the health and welfare of the nation that we should have a system that would make medical care and hospitalization available to all the people, you think there would not be anything unreasonable in asking all religious sects in the country to support that kind of system? MISS HALL: Yes.

SENATOR MURRAY: There would not be any injustice to them if they did not want to avail themselves of it, and they would not be compelled to. As a matter of fact, a good many of the members of that organization do fail to avail themselves of medical care or medical service, often to their great detriment in the final end. We had an ambassador from England here a few years ago who died as the result of his failure to call medical care, because he was a member of the Christian science sect, and as the result he died, and the physician afterward claimed that if he had only consulted a physician he could have lived many years. At any rate you find no difficulty in satisfying your mind that the American people have a right to have that form of health care and hospitalization in this country which is necessary for the protection of the health and for the welfare of the American people? MISS HALL: Yes, I have no difficulty whatsoever.

Statement of Miss Caroline F. Ware of the American Association of University Women

MISS WARE: I am glad of the opportunity to express to this committee the support of the American Association of University Women for the National Health Bill, S. 1606. Many of our 80,000 members and over 900 branches, in communities large and small throughout the country, have been deeply concerned with the health needs of their communities. The fact that we have received more orders for our study guide, "Medical Care for Everybody?" than for any other guide which we have issued in recent years is evidence of the very widespread interest in the subject among our members and their determination to study and inform themselves on the problems and issues involved.

On the basis of such study throughout the association, our convention last May voted eleven to one in favor of federal "measures to enhance the health and efficiency of the population, including continuation and expansion of the rehabilitation program for both veterans and civilians, an effective nutrition program and federal funds, if necessary, for the extension of hospital and other public health facilities and personnel."

SENATOR DONNELL: May I ask a question here? I do not observe in what you have read as the action of the convention last May any specific mention in terms of compulsory health insurance. Is that mentioned in it? MISS WARE: Our latest program also includes extension of coverage of social security. The national committees of our association, whose responsibility it is to interpret action of the convention in terms of specific legislation, have found that S. 1606 embodies the principles stated by the convention. Our procedure is this: We never act on anything which we have not studied first. Then a tentative legislative program in terms of general principles is drafted. It is submitted to all the branches of the association who will study and discuss it, and they express their opinions. It is not a vote. It is simply an opinion. Before the drafting of the program it is in the hands of two national committees, one in the field and one general legislative committee, and of course it is in the hands of the board. Then this proposal goes to our branches. They study it and discuss it and express their views on it. On the basis of the views expressed by the branches, the proposed program is revised and it is then submitted for vote by the convention in terms of general principles. Then as each piece of legislation comes up the legislation is referred to the same national committee, the committee in the field, in this case the National Social Studies Committee, and the Legislative Committee. Then those committees determine as to whether in their judgment the principles voted on by the convention include the legislation in question. That procedure has been followed with respect to the bill at hand.

SENATOR DONNELL: May I ask you one or two other questions? How large an attendance was there at the convention last May in which this vote occurred of 11 to 1? MISS WARE: The convention was not held physically because

of the transportation difficulty. It was held by mail from each community, and the numbers of the votes were approximately 2,000.

SENATOR DONNELL: And that vote of 11 to 1 was in favor of "measures" down to the word "personnel"? MISS WARE: Yes. And also approximately the same or slightly higher for the development of the Social Security program, including an extension of coverage, protection of veterans' rights under old age and survivor's insurance, temporary and permanent disability insurance and other items which I will not take the time to read.

SENATOR DONNELL: The two committees interpreted this resolution? MISS WARE: Yes.

SENATOR DONNELL: What is the total membership of those two committees? MISS WARE: Ten or a dozen people on each committee.

SENATOR DONNELL: So from twenty to twenty-five women constitute the membership of those two committees? MISS WARE: Yes.

SENATOR DONNELL: And those twenty to twenty-five individuals have undertaken to interpret the meaning of approximately 2,000 persons' expressions? MISS WARE: That is a continuing process in our association.

SENATOR DONNELL: Which is what happened? MISS WARE: That is the way in which our democratic procedure works, just as you represent your district and interpret as an individual what you think are the ideas of your district.

SENATOR DONNELL: You state that "our convention voted 11 to 1." That should be revised to say that there was not any convention? MISS WARE: Yes, there was a convention. It was a convention by mail. It went through all the convention procedures and according to the judgment of our parliamentarians completely conformed with the convention form prescribed.

SENATOR DONNELL: As I understand it, "convention" means coming together, "con venio." MISS WARE: You will have to argue with our parliamentarians and the Office of Defense Transportation, who concluded that this was a bona fide convention. The procedure was all gone through. We used transcriptions for the speeches and in every way held a wartime convention conforming with the requirements of the Office of Defense Transportation and with our own by-laws.

SENATOR DONNELL: How many people were present at this convention? MISS WARE: The delegates.

SENATOR DONNELL: Did you come together at all? Did anybody come together? MISS WARE: No.

SENATOR DONNELL: And yet you call that a convention? MISS WARE: Certainly.

SENATOR DONNELL: I doubt exceedingly if the Office of Defense Transportation would have considered you were violating any regulation which was purely on paper and not actually accompanied by physical attendance. MISS WARE: We did it in order not to violate the regulation.

SENATOR DONNELL: You realize, do you not, that there was no convention held? MISS WARE: No, I certainly do not.

SENATOR DONNELL: I certainly do. There could have been no convention held when you did not come together. MISS WARE: I am merely quoting the judgment of our parliamentarians on the basis of our analysis of the rules and by-laws, which call for convention. It was not my independent judgment, please understand. I am merely giving the source of judgment that we held a convention legally and conducted convention business last May.

SENATOR DONNELL: But in the resolution which was voted on by mail there is no specific mention of compulsory health insurance? I am right, am I not? MISS WARE: You have the text as I have quoted it.

SENATOR DONNELL: I say, I am correct in stating that there is no express mention of compulsory health insurance? MISS WARE: Senator, you can read it.

SENATOR DONNELL: Could you just answer that question? Is there anything in the resolution other than what is stated here? MISS WARE: Why do you ask the question when you have the text before you?

SENATOR DONNELL: I ask you, is there any specific mention of compulsory health insurance in the resolution adopted by the process you have described? MISS WARE: I have read you the text. I do not see why you are asking the question.

SENATOR DONNELL: I just want you to answer it. MISS WARE: Why do you want me to answer it?

SENATOR DONNELL: I want to know if there is any express mention of compulsory health insurance. MISS WARE: Do you want me to read it?

SENATOR DONNELL: No, ma'am. I heard you. Was there any mention of compulsory health insurance in anything that your convention, so called, adopted? MISS WARE: I have read you the text.

SENATOR DONNELL: Do you decline to answer that question? MISS WARE: I answered it with the text.

SENATOR DONNELL: May I ask you this, then: Is there anything in this text or anywhere else adopted by this so-called convention which contains express mention of federal compulsory health insurance? MISS WARE: No.

SENATOR DONNELL: Very well. That is all right.

(Miss Ware presented a prepared statement indicating that her organization favors Senate bill 1606.)

APRIL 10, 1946

HONORABLE JAMES E. MURRAY Presiding

PRESENT: Senators Murray, Donnell and Smith

Statement of Dr. Clark Foreman, President of the Southern Conference for Human Welfare

DR. FOREMAN: The Southern Conference for Human Welfare is a nonprofit organization working for the betterment of the South in order to help improve the whole nation. We unequivocally endorse the President's National Health Program and S. 1606, the Wagner-Murray-Dingell National Health Bill, the main measure to carry it out. We in the South know a lot about ill health and inadequate medical care, because we have more of both than any other section of the country. We have worse Selective Service rejection infant and maternal mortality rates than does any other part of the country. We have fewer doctors, dentists and hospitals than any other section; and yet, because of lack of purchasing power, we do not even utilize fully those we do have. Our rural and our Negro populations are hit the hardest, but our industrial workers and the middle income group are not so much better off. The Southern states had a 40 per cent higher Selective Service rejection rate than the rest of the nation. Our rejection rate was 50.4 per cent, while that of the rest of the country was 35 per cent.

. . . . . .

Our maternal mortality rate is 3.6 deaths per thousand; that of the rest of the country 2.2, or 40 per cent less. Our infant death rate is 48.6; that of the non-South 40.6. The two main sources of this misery are clear, namely poverty and inadequate medical services. What are the inadequacies of our health service? Our sanitation is miserable. According to the U. S. Public Health Service 657,799 Southern rural homes have not so much as an outdoor privy, much less an indoor toilet. Does private or voluntary health insurance offer us the way out? We do not think so. The private medical insurance we can get now is far too expensive and does not meet our health needs. The commercial policies sold provide small amounts of cash, not medical care, in the event of disabling illness; but they have such a huge overhead that only 40 per cent of the premiums paid in comes back as benefits. The rest goes for company administrative costs, profits, commission and the like. Blue Cross hospitalization is good as far as it goes, but it does not go very far. If one belongs to an eligible group, it costs a family about $24 a year but covers only the hospital bill. Yet doctor services alone take three times as much in the average medical dollar. Most incomes are so low such an outlay is too much. There are some medical society plans available but they offer even less. They cost about as much as Blue Cross and cover only the surgical or obstetric fees. They do not cover preventive, diagnostic or home and office care. Much of the best we have now comes from government sponsored voluntary prepayment plans under the Department of Agriculture; but even these suffer from the inherent defects of voluntary medical insurance. The Farm Security Administration has been able to work wonders in assisting half a million low income farmers to form voluntary health associations for prepaid medical care. The associations have improved the health of these families considerably, but they are not enough. Adequate medical care costs $100 a year, according to experts, and poor families cannot raise such amounts, no matter how they pool their resources. Further, turnover in membership, low percentage of eligibles joining and other problems have beset these organizations.

. . . . . .

We expect to be entitled to go to our family doctor or any other doctor participating in the system, and most will participate, though they will not be forced to. Instead of putting our money on the line at the time we receive the care, or paying the bill later, we will go to the doctor or hospital when we need to. They will collect the money for the service rendered by a suitable arrangement with the insurance fund. There would be no direct financial dealings between doctor and patient. Instead there would be, as there ought to be, a strictly professional relationship. Doctors will not have to spend so much of their time and energy trying to collect bills, and we will not have to hold back on going to doctors because we cannot afford the cost. The same goes for the hospital.

SENATOR MURRAY: Thank you, Mr. Foreman. Have you studied the bill in detail, the various provisions of it? DR. FOREMAN: Senator, I have studied some of the provisions of it in detail. I have read the President's message and I have gone into certain aspects of it, but I have not studied the whole bill, item by item.

. . . . . .

SENATOR DONNELL: Dr. Foreman, are you a physician? DR. FOREMAN: No, sir.

SENATOR DONNELL: You hold a degree of what? DR. FOREMAN: Doctor of philosophy.

(*Dr. Foreman described his educational background.*)

Senator Donnell assumed the Chair.

SENATOR DONNELL: Doctor, the organization the Southern Conference for Human Welfare is how large an organization, and how is it constituted? DR. FOREMAN: It is composed of some six or seven thousand people who are voluntary joiners of it. Those in the South are members, and people outside the South who care to join, may do so as associate members.

(*Senator Donnell questioned Dr. Foreman closely as to his authority for stating the position of his organization.*)

SENATOR DONNELL: Now, had either the membership at any meeting held by it, or the board of representatives at any meeting held by it, prior to the meeting held in Durham, passed any resolutions with respect to S. 1606? DR. FOREMAN: Not with respect to this particular bill. We have, however, gone on record repeatedly as in favor of federal aid to health and education, and this is so completely in line with the policies of the membership and the board of the Southern Conference for Human Welfare throughout its history, that I, as president, feel perfectly qualified to take the responsibility of committing the board and the membership on it.

SENATOR DONNELL: Has either the membership or the board of representatives ever gone on record specifically with respect to compulsory health insurance? DR. FOREMAN: I am inclined to think that they have not.

SENATOR DONNELL: The point I desire to make, Doctor, in interrogating you, is that this organization composed of six to seven thousand people has never specifically passed on federal compulsory health insurance, nor has the board of twenty-six members, which is located, as you have indicated, in the South, passed specifically on federal compulsory health insurance; and it is you, one individual, even though you are the president, who is undertaking to express here the opinion of this great organization of six to seven thousand people, is that correct? DR. FOREMAN: That is correct, but what I want to repeat is that I am fully authorized to do so.

. . . . . .

SENATOR DONNELL: You have no present recollection of any affirmative action being passed by either the membership or the board, affirming their being in favor of compulsory health insurance, am I correct? DR. FOREMAN: I think that you are correct.

SENATOR DONNELL: Now, Doctor, you state in your statement here, in one place, quoting "We unequivocally endorse the President's National Health Program and S. 1606, the Wagner-Murray-Dingell National Health Bill, the main measure to carry it out." And yet, I understood you to testify that you have not studied all of this bill, is that correct? DR. FOREMAN: I have studied the President's message.

SENATOR DONNELL: But I am talking about S. 1606, which you denominate here as the main measure to carry out the President's National Health Program, and which measure you state that you "unequivocally endorse." DR. FOREMAN: That is right.

SENATOR DONNELL: Have you read all of that bill? DR. FOREMAN: No, sir.

SENATOR DONNELL: What portion of it have you read? DR. FOREMAN: I am not able to give you the fractions, Senator, but I feel that I have gone through it sufficiently to understand its content and its meaning, and I am perfectly willing to take the President's own analysis of it as adequate.

. . . . . .

SENATOR DONNELL: Now, Doctor, you refer on page 5 of your mimeographed statement, from which you have read, to what you call the "belated and extravagant claims of the American Medical Association"? DR. FOREMAN: Yes, sir.

SENATOR DONNELL: Have you ever attended a meeting of the American Medical Association? DR. FOREMAN: I have discussed in great detail with a representative of the American Medical Association their belated and extravagant claims.

SENATOR DONNELL: What do you mean by "belated"? DR. FOREMAN: I mean by that, about ten years ago they claimed that voluntary medical assistance even was communistic and socialistic and inciting to revolution.

SENATOR DONNELL: I am not clear as to what you mean by the term "belated." DR. FOREMAN: I mean that it is only now that they are even coming to the point of advocating voluntary health insurance. Ten years ago they thought it was communism.

SENATOR DONNELL: You know today the American Medical Association opposes very vigorously compulsory health insurance. DR. FOREMAN: I know that they do just as vigorously as ten years ago they opposed voluntary methods.

SENATOR DONNELL: And you also know that the American Medical Association is the largest single association of practicing physicians in the United States? DR. FOREMAN: That is right, even monopolistic, I would call it.

SENATOR DONNELL: Just what do you mean by that? DR. FOREMAN: I mean in the District of Columbia they attempted to insist on their rights as a monopoly and to break up at that time, which was about ten years ago, a voluntary medical association here in the District of Columbia.

SENATOR DONNELL: Now Doctor, you say on page 6 of your statement that doctors under this proposed bill, S. 1606, will not have to spend so much of their time and energy to collect bills. Do you regard this expenditure of time and energy which prevails under the present system in trying to collect bills as seriously impeding the efficiency of the physicians of this country? DR. FOREMAN: I do. I think that the medical profession is torn now in a dilemma between being a profession and being a business. I think the reason that the American Medical Association is opposed to this is because too many of its members, or too many of the people who are controlling its policy, are thinking in terms of their business rather than their profession.

(*Dr. Foreman stated his belief that the House of Delegates does not really represent the members of the American Medical Association; he questioned their motives; he gets his views from the Physicians' Forum.*)

(*Senator Donnell questioned Dr. Foreman closely as to his knowledge of the bill and as to his facts. It appeared Dr. Foreman did not know much beyond what had been prepared for him to read.*—ED.)

SENATOR DONNELL: Did you personally prepare any part of this statement, Doctor? DR. FOREMAN: I went over it, and it was brought to me in draft, and I went over it and changed it according to my ideas of what I wanted to say. I did not do it originally, the original work on it.

SENATOR DONNELL: Does the document as it now stands and as you read it, in substance, in the major points at any rate, stand precisely as it was when it was brought to you? DR. FOREMAN: In substance it stands as it was brought to me.

SENATOR DONNELL: Now, Doctor, this is not said critically but merely as a matter of information. You realize, of course, that this is a highly important measure, and in fact you characterize it as the main measure to carry it out, and you have come before the United States Senate committee to give us the benefit of your views, and yet several weeks have elapsed since you have examined this document, S. 1606, and you are unable to state with any certainty where you derived the information as to the method of financing that was proposed. Am I correct in those statements? DR. FOREMAN: You mean that I cannot now give you the reference for all of the figures here?

SENATOR DONNELL: I am talking about the financing of the health insurance program, as to how that is to be done. DR. FOREMAN: Well, I cannot now put my hands on it, no, sir. This 3 per cent is the figure that I have been going on,

that I felt and I still feel that I can verify the fact that one half of it comes from the employer and one half from the employee.

SENATOR DONNELL: I think that you will fail to find that in this title II. I may be in error in it, and if I am I stand corrected, but I do not think that you will find that. I think that you will find it in S. 1050. DR. FOREMAN: It is possible that I and my assistant have been confused on that.

SENATOR SMITH: Just one question, if I may. Doctor, what do you estimate would be the overall cost of the compulsory health program? Have you made estimates on that? DR. FOREMAN: No, sir, I have not. I will be very glad to get up a figure.

SENATOR SMITH: I have heard such strange figures, and I would like to know what the estimates are. It goes up as high as three or four billion dollars, and it is something that we ought to consider in relating it to our whole social program. DR. FOREMAN: What I have heard, and I cannot myself vouch for, is that it would be less than, or I think the cost would be very little more, if any, in total than the billion that is now being paid for all medical and health work, but because it would be for everybody and would be prepaid, the total medical bill would be lowered. In other words, as I understand it, the theory, and as I say this is hearsay, Senator, and I am not prepared to give you the figures on it, was because we would have general coverage, with preventive care for all of the people, that the total medical bill of the country would be considerably lower than it is at the preesnt time; and since it seems to me that we can think of it as a national problem, that would seem to me to answer the fundamental part of your question as to whether the country can afford health insurance.

SENATOR SMITH: Then you suggest as the philosophy behind the bill that everybody should stop paying their doctors and go into this plan and get their health taken care of by the overall government program, that is your theory? DR. FOREMAN: My theory is, if the bill is passed, that practically everybody will take advantage of the bill, including practically all of the doctors.

SENATOR SMITH: So that the doctor would no longer have the personal relationship with the patient as to his fees and so on, and there would be no difference in skills as far as the patient is concerned? DR. FOREMAN: I would say, because the doctor does not have to deal with his patients on the fees, there would be a more personal relationship with the patient. The doctor would be assured of his money and therefore would think of his patient only in a professional capacity.

SENATOR SMITH: Well, would that apply to any professional job? You might say that the lawyers would not have any fees in a law case. Why not put them on the basis of a niee, pleasant relationship, where you just call your lawyer and the government pays him? I am trying to get the philosophy of this bill. DR. FOREMAN: The Senator has given me caution, and I am not prepared to answer the legal question. But as far as the medical is concerned, I am absolutely convinced that the people would get better medical care under this bill, and that it would be of great benefit to the people in this country, particularly the Southern people.

SENATOR DONNELL: Doctor, may I ask you, for a moment, do you know a lady named Peggy Stein? DR. FOREMAN: Yes.

SENATOR DONNELL: Connected with the Department of Agriculture? DR. FOREMAN: I know her casually.

SENATOR DONNELL: Is she here today at the hearing? DR. FOREMAN: No, I do not think she is.

SENATOR DONNELL: Did she participate at all in the preparation of this document from which you have testified? DR. FOREMAN: So far as I know she did not.

(Senator Donnell questioned Dr. Foreman closely as to his unwarranted statement that doctors spend so much time and energy trying to collect their bills that they impair their efficiency.)

SENATOR DONNELL: You know of doctors who have spent so much of their time and energy trying to collect bills that they have impaired their usefulness to a material extent? DR. FOREMAN: I have known doctors who I thought impaired their therapeutic work, so to speak, because of their anxiety for the remuneration, for the patient's fees.

SENATOR DONNELL: Would you mind telling us whether you know a considerable number of doctors who have devoted so much time and energy to the collection of bills that they have interfered with their efficiency? DR. FOREMAN: I can only make the basis on the doctors I have known intimately, because doctors do not generally discuss this, and any casual discussion with a doctor would not bring out their anxiety about the collection of that bill.

SENATOR DONNELL: Doctor, you do not mean to tell us that you have observed personally any considerable number of doctors that have been devoting such an amount of time and energy to the collection of bills as to interfere materially in your judgment with their efficiency? I am correct in that, am I not? DR. FOREMAN: Senator, you pin me down to the point where I hesitate to answer. All I can say is that my best judgment and belief is that many doctors are sufficiently disturbed about the difficulties of collecting their fees that it does interfere with their medical activities. That I am prepared to stand by.

SENATOR SMITH: Mr. Chairman, I would like to interrupt for the record to interpose an experience. SENATOR DONNELL: Yes, sir.

SENATOR SMITH: I assume I was raised from the atmosphere of the medical men. I think there is no greater profession than the profession of medicine. I think the witness would agree. DR. FOREMAN: I would.

SENATOR SMITH: I never knew of one in all my years ever concerned with the financial side of his practice. The way they are, they do not give enough attention to it. SENATOR DONNELL: That has been my experience.

SENATOR SMITH: Lots of them make personal sacrifices and pay no regard whatsoever to the question of collecting the fee. They were interested in the body and spirit of the patient. My father was like that. I would like to say, Senator, there may be a few exceptions, but the general experience of the medical profession has been so high that I am unwilling to have the statement made here and let it go unchallenged that doctors are thinking in terms of dollars and cents.

SENATOR DONNELL: I would like to be recorded also as sharing your opinion, not from personal knowledge, because I have never been in a physician's family, but my experience has been that the medical profession has been extremely unjust to itself in that it has not given as much interest to collecting fees as it should have done. I think it is to be commended for that; and I would not share in the view that doctors have devoted so much time and energy to collecting their bills that they have impaired their efficiency. I want to say this in fairness to Dr. Foreman, that he does not say that in so many words. I want to read the sentence. He says "Doctors will not have to spend so much of their time and energy trying to collect bills, and we will not have to hold back on going to doctors because we cannot afford the cost." That is the statement he made, but I certainly do not concur in the view that I have ever known any doctor who I thought devoted so much time and energy going out collecting bills that he could not give attention to his patients.

DR. FOREMAN: I think unquestionably some of the great philanthropists of the human race are in the medical profession, but I think also that doctors are human beings. I would like to give one instance in my own experience with the medical system of Atlanta, Ga., which has regular meetings—or did have at the time this happened. I am not sure whether the custom persists today. They excluded from these meetings all Negro doctors in Atlanta, Ga., and I, in my concern for the health of the people of Atlanta, including the Negro people, went before that body and appealed to them to allow the Negro doctors to sit in and hear their discussions once a month of current medical problems, so that the Negro doctors of the city of Atlanta would be able to keep abreast of medical information and carry that to their people. In doing so I did it with the encouragement and blessing of some of the finest doctors of Atlanta, I want to make that clear. All we were asking for at that time was that the Negro doctors be allowed it sit in and hear, so that they could keep current with the discussion; and that was turned down by this medical society, and as it was explained to me by the doctors in Atlanta, the reason for turning it down was that so many of the doctors there did not want the Negro doctors to keep abreast of the situation because they did not want to lose their clients, or patients, to the Negro doctors. Now, that seems to me to indicate that there are a number of the members of the medical profession very much concerned about collecting their bills.

(Senator Donnell again questioned Dr. Foreman closely as to what the bill would do for freedom of choice of physician.)

SENATOR DONNELL: Is that not one of the important bases of the opposition of the American Medical Association, that they do not favor the federalization of control of the American government of patients and doctors; is that not one of the important bases of the opposition? DR. FOREMAN: I do not think it is; no.

SENATOR DONNELL: You do not think it is. DR. FOREMAN: No. There is no federal control of the relation of doctor over patient in this bill.

SENATOR DONNELL: I think we might disagree on that, but I shall not go into this point with you.

SENATOR AIKEN: I was just wondering, Dr. Foreman, in the Southern conditions, what progress has been made in the South in improving health and providing medical care in the last few years? DR. FOREMAN: I think the greatest has been done through the supplemental work of the Farm Security Administration, Senator. And we have had a chance to get medical care on a much more basic plan than ever before, although even that is selective.

SENATOR AIKEN: You say the syphilis mortality is above the national average; and the tuberculosis, influenza and pneumonia rates are higher than elsewhere. How do the percentages of illness and death compare with what it was ten or twenty years ago? DR. FOREMAN: It is less, Senator, but it is still far higher than the rest of the country.

(To be continued)

Medical Legislation

STATE LEGISLATION

Massachusetts

Bill Passed.—S. 462 passed the senate April 11. Relating to the replacement of a city board of health by a city health department, it proposes that the commissioner of health shall be a citizen of the United States who has been graduated from a medical school approved by the state authority for the approval of medical schools and either shall be the holder of a degree of public health with at least two years' full time experience in a responsible position in public health service or shall have had four years' full time experience in a responsible position in such service. He shall be eligible to be registered to practice medicine under the laws of the state.

Bill Enacted.—H. 298 has become chapter 194 of the Laws of 1946. To amend the law relating to the practice of pharmacy, it authorizes the board and the commissioner of education to establish standards to be met by colleges of pharmacy, to grant certificates of approval to colleges meeting such standards and to revoke any certificate of approval previously issued to any college which lowers its standards below that established by the board and the commissioner.

Mississippi

Bills Enacted.—H. 699 was approved April 10. It authorizes the state board of examiners to proceed by injunction to prohibit any person from practicing any profession licensed under the supervision of said board when such person is not duly licensed so to practice, except persons practicing chiropractic, osteopathic or veterinary sciences. H. 1038 was approved April 4. Amending the law relating to the hospitalization of charity patients, it increases the amount payable for hospitalization and surgical care and provides that no hospital shall receive any funds provided for by this act unless such hospital shall have been inspected and approved by the state board of health.

Missouri

Bill Enacted.—S. 435 was approved April 12. Relating to the licensing of chiropractors, it transfers to the executive secretary of the division of registration and examination of the state department of education certain powers heretofore vested in the state board of chiropractic.

New Jersey

Bills Introduced.—A. 317 proposes the enactment of a cash sickness compensation act. A. 365 proposes the enactment of a nonoccupational accident and sickness benefit law.

Bills Passed.—S. 197 passed the house April 11. Relating to coroners' and county physicians' reports, it proposes that whenever an autopsy or chemical analysis is deemed necessary the county physician, or the coroner, shall cause a report of the findings of such autopsy, chemical analysis or other test to be filed with the county prosecutor's office, and such report shall be available for inspection to all officials, doctors or citizens having an established legitimate interest in the same. S. 278 passed the house April 11. To amend the law relating to medical service corporations, it proposes, according to a statement attached to the bill, "to enable veterans with service connected disabilities to choose their own personal physician and to be treated in local hospitals that have been designated by the Veterans Administration."

New York

Bills Enacted.—A. 1249 has become chapter 699 of the Laws of 1946. Amending the law relating to the practice of osteopathy, it provides that persons holding a license to practice osteopathy who have been granted the additional rights provided for under existing statutes and persons who shall meet all the preliminary and professional requirements required as of Sept. 1, 1936 and have satisfactorily passed or shall satisfactorily pass the regular medical licensing examination shall be granted the right to practice medicine without limitation as defined by the statutes of the state of New York. A. 1595 has become chapter 712 of the Laws of 1946. It provides for the creation of a medical director in the county of Erie who shall be a duly qualified practitioner of medicine and surgery, a graduate of a medical school, and have had at least five years' actual experience in the practice of his profession. He is to take over the duties now vested in the medical examiner. A. 1973 has become chapter 674 of the Laws of 1946. It amends the state licensing law by providing that persons lawfully inducted into the military service who were licentiates under the state law at the time of their induction may apply for, and be entitled to, a renewal of their license within three months of discharge from the service or within three months of discharge from any period of hospitalization in a facility maintained by the United States Veterans Administration. This is without examination, reexamination, fine or penalty. A. 2377 has become chapter 675 of the Laws of 1946. It authorizes corporations organized under the consumers' cooperative stock corporation law for the purpose of furnishing medical expense indemnity service to persons who become subscribers under contracts with such corporation to reincorporate under the membership corporations law. A. 2739 has become chapter 666 of the Laws of 1946. It authorizes the state department of taxation and finance to receive from the federal government any moneys which the federal government shall offer to the state to assist to inventory its hospitals, to survey the need for construction of hospitals, to develop a program for construction of public and other nonprofit hospitals and to construct such hospitals in accordance with such program, and generally for all the purposes for which any such moneys shall be offered pursuant to any federal law. The term "hospitals" includes public health centers and related facilities. S. 1319 has become chapter 597 of the Laws of 1946. It amends the law relating to hypnotic and somnifacient drugs by prohibiting prescriptions therefor from being refilled if the prescription bears a direction to that effect and authorizes the prescribers to indicate the number of times a prescription may be refilled. If the prescription is silent as to refilling, then the prescription may be refilled by the pharmacist during a period of not more than six months from the original date of the prescription. A pharmacist is prohibited from furnishing a copy of the prescription to the patient. S. 1542 has become chapter 698 of the Laws of 1946. It amends the education law by providing a number of amendments relating to the practice of pharmacy. S. 1563 has become chapter 697 of the Laws of 1946. It provides for the creation of a board of examiners in ophthalmic dispensing.

Rhode Island

Bill Passed.—H. 771 passed the house April 12. It proposes an appropriation to the state department of health to carry on an experimental dental research study in administrative practice in conjunction with the United States Public Health Service.

South Carolina

Bill Enacted.—H. 1446 was adopted March 30. It resolves that the officials of the schools in Anderson County be requested to accept certificates signed by chiropractors as well as by medical doctors as to disability preventing pupils from attending school.

National Health Program

PLATFORM ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION

One of the ten points in this platform will be published each week.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

Official Notes

"DOCTORS AT HOME" TIME CHANGED

With the beginning of Daylight Saving Time in various parts of the United States as of the last Sunday in April, the broadcast time of "Doctors at Home" will be changed. Beginning May 4 "Doctors at Home" will be heard on the NBC network from 4:30 to 5 p. m., Eastern Daylight Saving Time (3:30 to 4 Central Daylight Saving Time, 2:30 to 3 Mountain Daylight Saving Time, 1:30 to 2 Pacific Daylight Saving Time). Wherever Standard Time is observed, the program will be one hour earlier.

Following are the programs scheduled for the remainder of the series:

April 27. Tuberculosis.
May 4. Child behavior.
May 11. Mushroom poisoning.
May 18. Highway safety.
May 25. Trichinosis.
June 1. Health education.
June 8. Medicine in the future.

These programs will be summarized alternately by Drs. W. W. Bauer and William W. Bolton, respectively Director and Assistant Director of the Bureau of Health Education.

Washington Letter

(From a Special Correspondent)

April 22, 1946.

Veterans Administration Appoints Psychiatrists

Dr. James G. Miller, the 29 year old psychiatrist who helped develop new technics for selecting undercover agents for the Office of Strategic Services, has been named chief of the division of clinical psychology in the Veterans Administration. Dr. Rutherford B. Stevens, aged 39, first Negro doctor appointed to the staff of a Veterans Administration Hospital not exclusively for Negro veterans, was appointed resident psychiatrist at the Winter General Hospital, Topeka, Kan., on approval of Dr. Karl Menninger, who is directing the agency's neuropsychiatric activities. A recommendation for Stevens was also made by Brig. Gen. William Menninger, brother of Karl and chief of the army psychiatric division. The Veterans Administration also reports that it is setting up sixteen artificial eye laboratories to serve approximately 89,000 blinded veterans.

Opposition to Deferments for Fathers of Illegitimate Children

Representative Cooley, Democrat of North Carolina, asked the House to eliminate from draft extension legislation provisions that would "give expectant fathers of illegitimate children" a deferment from the draft. A section exempts any one who has a child, and a child is described as "a legitimate or illegitimate child from the date of its conception." Representative Cooley declared "The draft board then becomes a bastardy court . . . the next thing you know you'll be giving these fellows a Distinguished Service Cross." Incidentally, legislation was introduced in the House by Representative Beall, Republican of Maryland, to protect illegitimate children adopted by people outside the District of Columbia. The bill provides for a new birth record in the new name to be issued.

Bill Would Give Amputees New Automobile

Representative Rogers, Republican of Massachusetts, has introduced a bill in the House which would grant to any veteran who has lost a limb or the use of a limb through service incurred injuries a $1,500 automobile or an equal cash payment. The measure was drawn up in cooperation with the Veterans Administration. It provides that the grant shall be made by the agency when the automobile "would enable the veteran to engage in gainful employment notwithstanding such disability." Representative Kelley, Democrat of Pennsylvania, said he would introduce a similar measure.

Meeting of State and Territorial Health Officers

The Association of State and Territorial Health Officers met in Washington, with sessions in various hotels. Deputy Surg. Gen. Warren F. Draper of the U. S. Public Health Service opened the conference with an appeal for passage of public health bills pending in Congress. He spoke in behalf of Surg. Gen. Thomas Parran, who is in Paris arranging for the international health organization conference in June. Dr. James A. Hayne, who was South Carolina health officer thirty years before retiring, presented an honorary life membership to Dr. F. W. Cogswell, Montana state health officer for thirty-three years.

President Proclaims Child Health Day May 1

Proclaiming May 1 as Child Health Day, President Truman has urged the American people to seek improved health conditions for children. He said "I call on the people in each of our communities to pledge themselves to review their community health and medical care services to see how well these services meet the needs of our children in the light of the goals of the national health program and to organize a definite plan to achieve within the coming year at least one improvement in community health services which will contribute to the better health of children."

Miners and Operators Stymied on Lewis Health Proposals

United Mine Workers President John L. Lewis states that a demanded health and welfare fund for miners must be provided by operators on a tonnage basis if the present soft coal mine contract deadlock is to be broken. Coal production has been stymied for some time, with neither side indicating that it would yield. Operators claim a 10 cent a ton assessment on coal mined for a health and welfare fund would add $200,000,000 annually to the coal bill of the United States.

Drive on Prostitution as Army Venereal Rate Rises

Informed of the first sharp rise in the venereal disease rate of the army since 1902, Chief of Staff Dwight D. Eisenhower has endorsed the continuous military drive against vice conditions. He has ordered all commanders in this country and overseas to declare all identified houses of prostitution "off limits." A spokesman said that the all time low rate of 28 cases of infection per thousand men in 1943 had risen to 69 cases per thousand men last year and is still mounting.

Lack of Personnel Blamed for Fifty or More Infant Deaths

The District of Columbia Commissioners charge, in a report to Capitol Hill asking the Senate to restore an appropriation to employ additional nurses, that "inadequate care" was responsible for more than a third of the 146 deaths of babies in Gallinger Municipal Hospital. The report revealed that babies born at Gallinger between 11 p. m. and 7 a. m. are cared for only by "untrained domestic attendants."

Increase in Production of Penicillin

The Civilian Production Administration estimates that production of penicillin is now about 300 per cent that of last December, with more penicillin now being available for export to meet pressing needs overseas. Although production of

streptomycin, new companion drug to penicillin, is still too low to meet military needs, 32 per cent of the supply has been allocated this month for civilian and research purposes.

Simple Test for Diagnosis of Spotted Fever

Comdr. Norman H. Topping, senior surgeon of the U. S. Public Health Service, told the George Washington University Medical Society that the long sought test to diagnose Rocky Mountain spotted fever accurately may have been found. He has asked District of Columbia doctors to bring in suspected cases to the service for testing. Commander Topping said that the former test for fever took so long that before it was completed the patient was either well or dead. He says there is a possibility that the newly discovered laboratory process may offer a quick and accurate diagnosis. The best preventive of the fever is said to be the old fashioned immediate examination of adults and children after they come in from infected areas. Instances of the fever have been reported this year in all forty-eight states. Dr. James G. Cummings, director of the communicable disease bureau of the District of Columbia, reports that any patient suddenly afflicted with "a splitting headache, rising temperature and rash on the hands and ankles" is a potential spotted fever case.

Use of Hospital Ship for Venereal Disease Clinic

A 300 bed hospital ship, turned over to the United States Public Health Service at Norfolk, may be anchored at Washington for use as a venereal disease clinic for patients from the District of Columbia, Maryland and Virginia. Public health officials propose that the ship be used for the twelve day penicillin treatment. Among those attending the ceremonies when the Army turned over the ship to the Public Health Service were Dr. I. C. Riggin, Virginia health commissioner; Representative McMillan, Democrat of South Carolina; Dr. John R. Heller, assistant surgeon general and director of the Venereal Disease Division of the Public Health Service; Dr. R. H. Reilly, Maryland state health commissioner, Dr. Ross Taggart, District of Columbia venereal disease director, and Dr. George Ruhland, District of Columbia health officer.

Use of Streptomycin in Treating Bubonic Plague

Dr. J. W. Hornibrook of the U. S. Public Health Service reports successful use of streptomycin in animal experiments for the treatment of bubonic plague. The drug is not yet in commercial production. It can be obtained for civilians only through Dr. Chester S. Keefer of the Evans Memorial Hospital of Boston, member of the National Research Council, who had control of all commercial use of penicillin up to the end of the war. The Civilian Production Administration and the War Department reveal that a $20,000,000 plant construction program is scheduled to provide an ample supply of streptomycin. With special priorities one commercial plant will be in production next month and several others will be operating before the end of the year.

Advocacy of Extension of Mental Hygiene

Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital and professor of psychiatry at George Washington University School of Medicine, told the American Philosophical Society in Philadelphia that "fully half of the hospital beds of the United States are in mental hospitals." He advocated extension of the principles of mental hygiene to the schools and industry, expansion of facilities for the early extramural attention to mental symptoms, development of psychiatric wards in general hospitals and continuing and expanding research into the problems of mental disorder.

Increased Production of Penicillin

Dr. Donald Grove, assistant chief of the division of penicillin control and immunology, Food and Drug Administration, reports that there is a vastly increased supply of penicillin now available. Some doctors complain that commercial manufacture has reduced the quality. Dr. Grove said that tests are being made to determine whether the present penicillin K is as effective as types G, F and X.

Coming Medical Meetings

American Association for the Study of Goiter, Chicago, June 20-23. Dr. Thomas C. Davison, 478 Peachtree St., N.E., Atlanta 3, Ga., Secretary.

American Association for Thoracic Surgery, Detroit, May 29-31. Dr. Richard H. Meade Jr., Kennedy General Hospital, Memphis 15, Tenn., Secretary.

American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 20-22. Dr. Charles C. Higgins, 2020 E. 93d St., Cleveland 6, Secretary.

American Association of Plastic Surgeons, Toronto, Canada, June 3-4. Dr. Frederick A. Figi, 102 Second Ave., S.W., Rochester, Minn., Secretary.

American Association of the History of Medicine, Atlantic City, May 26-27. Mr. W. B. McDaniel II, 19 S. 22d St., Philadelphia 3, Secretary.

American Broncho-Esophagological Association, Chicago, May 31. Dr. Paul H. Holinger, 700 N. Michigan Ave., Chicago 11, Secretary.

American College of Physicians, Philadelphia, May 13-17. Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Executive Secretary.

American Dermatological Association, Hot Springs, Va., June 10-14. Dr. Harry R. Foerster, 208 E. Wisconsin Ave., Milwaukee, Secretary.

American Federation for Clinical Research, Atlantic City, May 28. Dr. Richard H. Lyons, University Hospital, Ann Arbor, Mich., Secretary.

American Gastro-Enterological Association, Atlantic City, May 24-25. Dr. J. Arnold Bargen, 102 Second Ave., S. W., Rochester, Minn., Secretary.

American Laryngological Association, Chicago, May 29-30. Dr. Arthur W. Proetz, 3720 Washington Blvd., St. Louis 8, Secretary.

American Laryngological, Rhinological and Otological Society, Chicago, May 27-28. Dr. C. Stewart Nash, 277 Alexander St., Rochester 7, New York, Secretary.

American Otological Society, Chicago, May 31-June 1. Dr. Gordon D. Hoople, 713 E. Genesee St., Syracuse, N. Y., Secretary.

American Pediatric Society, Skytop, Pa., May 1-3. Dr. Hugh McCulloch, 325 N. Euclid Ave., St. Louis 8, Secretary.

American Psychiatric Association, Chicago, May 27-30. Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington 20, D. C., Secretary.

American Society for Clinical Investigation, Atlantic City, May 27, Dr. Eugene A. Stead Jr., Grady Hospital, Atlanta 3, Ga., Secretary.

American Society for Research in Psychosomatic Problems, New York, May 11-12. Dr. Edwin G. Zabriskie, 714 Madison Ave., New York 21, Secretary.

American Therapeutic Society, Atlantic City, May 11-12. Dr. Oscar B. Hunter, 1835 I St., N.W., Washington, D. C., Secretary.

Arizona State Medical Association, Phoenix, May 2-3. Dr. Frank J. Milloy, 112 N. Central Ave., Phoenix, Secretary.

Association of American Physicians, Atlantic City, May 28-29. Dr. Joseph T. Wearn, 2065 Adelbert Road, Cleveland 6, Secretary.

California Medical Association, Los Angeles, May 7-10. Dr. George H. Kress, 450 Sutter St., San Francisco 8, Secretary.

Connecticut State Medical Society, Hartford, May 1-3. Dr. Creighton Barker, 258 Church St., New Haven 10, Secretary.

Georgia, Medical Association of, Macon, May 7-10. Dr. Edgar D. Shanks, 478 Peachtree St., N.E., Atlanta, Secretary.

Illinois State Medical Society, Chicago, May 14-16. Dr. Harold M. Camp, 224 S. Main St., Monmouth, Secretary.

Louisiana State Medical Society, Alexandria, May 6-8. Dr. P. T. Talbot, 1430 Tulane Ave., New Orleans 13, Secretary.

Massachusetts Medical Society, Boston, May 21-23. Dr. Michael A. Tighe, 8 Fenway, Boston, Secretary.

Minnesota State Medical Association, St. Paul, May 20-22. Dr. B. B. Souster, Lowry Medical Arts Bldg., St. Paul 2, Secretary.

Mississippi State Medical Association, Jackson, May 14-15. Dr. T. M. Dye, Box 295, Clarksdale, Secretary.

National Tuberculosis Association, Buffalo, N. Y., June 11-13. Dr. Charles J. Hatfield, 1790 Broadway, New York 19, Secretary.

Nebraska State Medical Association, Lincoln, May 6-9. Dr. R. B. Adams, 416 Federal Securities Bldg., Lincoln 8, Secretary.

New Hampshire Medical Society, Manchester, May 14. Dr. C. R. Metcalf, 5 S. State St., Concord, Secretary.

New Jersey, Medical Society of, Atlantic City, May 21-23. Dr. Alfred Stahl, 55 Lincoln Park, Newark, Secretary.

New York, Medical Society of the State of, New York, April 29-May 3. Dr. Walter P. Anderton, 292 Madison Ave., New York 17, Secretary.

North Carolina, Medical Society of the State of, Pinehurst, May 1-3. Dr. Roscoe D. McMillan, P. O. Box 232, Red Springs, Secretary.

North Dakota State Medical Association, Bismarck, May 26-28. Dr. L. W. Larson, 221 Fifth St., Bismarck, Secretary.

Ohio State Medical Association, Columbus, May 7-9. Mr. Charles S. Nelson, 79 E. State St., Columbus, Executive Secretary.

Oklahoma State Medical Association, Oklahoma City, May 1-3. Dr. Lewis J. Moorman, 210 Plaza Court Bldg., Oklahoma City, Secretary.

Rhode Island Medical Society, Providence, May 15-16. Dr. William P. Buffum, 122 Waterman St., Providence 6, Secretary.

Society of American Bacteriologists, Detroit, May 21-24. Dr. Leland W. Parr, 1335 H St., N. W., Washington 5, D. C., Secretary.

South Carolina Medical Association, Myrtle Beach, April 30-May 2. Dr. Julian P. Price, 105 W. Cheves St., Florence, Secretary.

South Dakota State Medical Association, Aberdeen, June 1-4. Dr. Roland G. Mayer, 22½ S. Main St., Aberdeen, Secretary.

Texas, State Medical Association of, Galveston, May 6-9. Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

West Virginia Medical Association, Huntington, May 13-15. Mr. Charles Lively, P. O. Box 1031, Charleston 24, Executive Secretary.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

ALABAMA

Wilmot Littlejohn Named Neurology Head.—Dr. Wilmot S. Littlejohn, Birmingham, has been named head of the newly created department of neurology in the division of medicine at the Medical College of Alabama, Birmingham, according to the Birmingham *News*. Dr. Littlejohn will also be associate professor of clinical medicine for neurology. He graduated at Emory University School of Medicine, Atlanta, in 1921.

CALIFORNIA

Ninety Years of Age.—Dr. Flora M. Watson-Reeves, Los Angeles, who graduated at Hering Medical College, Chicago, in 1893, recently observed her ninetieth birthday.

Dr. Götzl Dies.—Dr. Alfred Götzl, who has been living in San Francisco for some years, died there January 21. He was a former head of the tuberculosis division of the city of Vienna, Austria.

State Board Agent Resigns.—Walter N. Anderson, chief special agent for the California State Board of Medical Examiners, has resigned to enter private law practice, it was announced February 11. He will be succeeded by Maynard C. Youngs.

Personal.—The Los Angeles Surgical Society was addressed March 8 by Dr. Frank H. Lahey, Boston, on "Some of the New Developments in Thyroid Disease, Including Thiouracil and Thiobarbital." He was awarded honorary membership in the society.——Dr. Harry E. Zaiser, Orange, has resigned as superintendent of the Orange County Hospital after holding the position for thirty-one years.

New Tuberculosis Secretary.—Mr. Patrick Kelley, who recently returned from the Pacific area, where he served for four years as a lieutenant commander in the U. S. Navy, has been appointed executive secretary of the San Francisco Tuberculosis Association to succeed Mr. Paul Neiman, who resigned in March. Prior to enlistment Mr. Kelley was public relations director of the San Francisco Community Chest.

The Pierson Research Fund.—The Alum Rock Sanatorium, San Jose, has received a gift of $5,000 for medical research to be known as the Philip H. Pierson Memorial Research Fund. Dr. Pierson, clinical professor of medicine, Stanford University School of Medicine, San Francisco, died January 17. He was consultant to the sanatorium. The fund has been set up as a "dedication to Dr. Pierson's unselfish devotion and scientific attainments in the field of medicine, particularly diseases of the chest," according to the *Bulletin* of the San Francisco County Medical Society.

Department of Neurology Created.—Dr. Charles D. Aring, Cincinnati, April 1, assumed the position of professor of neurology at the University of California Medical School, San Francisco, and the chairmanship of the newly created department of neurology for the university. The department of neurology will be housed eventually in the new development on the San Francisco campus, where beds, laboratories and offices will be located convenient to those of the other services. It is planned that neurology will be integrated with related disciplines rather than isolated in the style of a neulorogic unit. Dr. Ephraim Roseman, formerly instructor in neurology at the University of Cincinnati College of Medicine and at present a major in the U. S. Army Medical Corps in charge of neuropsychiatry at the 317th Station Hospital in Wiesbaden, Germany, will join the department at the University of California Medical School as assistant professor of neurology at the termination of his military service.

CONNECTICUT

Portrait of Robert Yerkes.—During a reception in honor of Robert M. Yerkes, Ph.D., professor emeritus of psychobiology at Yale University School of Medicine, New Haven, in the Sterling Hall of Medicine, April 4, a portrait, the work of Clarence Brodeur, was presented to the university. Dr. Yerkes, who had been a member of the staff of Yale since 1924, recently became emeritus professor. He has been chairman of the committee on research of problems of sex, National Research Council, since 1922.

GEORGIA

State Medical Meeting.—The Medical Association of Georgia will hold its 1946 meeting in the City Auditorium, Macon, May 7-10, under the presidency of Dr. Cleveland Thompson Millen, who will speak on "The Doctor in This New Day." The Bibb County Medical Society will act as host. Among the speakers will be:

Dr. Oswald S. Lowsley, New York, Correcting Some of Nature's Mistakes by Surgical Intervention.
Dr. Harrison H. Shoulders, Nashville, Our Battle for Freedom.
Dr. Jean P. Pratt, Detroit, Psychosomatic Gynecology.
Dr. Marcas Fernan-Nunez, Milledgeville, Tropical Diseases in the African Negro.

The Abner Wellborn Calhoun Lecture will be delivered Wednesday by Dr. Winchell M. Craig, Rochester, Minn., on "The Early Diagnosis of Neurosurgical Conditions."

ILLINOIS

Chicago

Harold Lueth Goes to Nebraska.—Dr. Harold C. Lueth, associate professor of medicine, University of Illinois College of Medicine and formerly liaison officer between the Surgeon General's Office, U. S. Army, and the American Medical Association, has been appointed dean of the University of Nebraska College of Medicine, Omaha, and superintendent of the University of Nebraska Hospital. Dr. Lueth graduated at Northwestern University Medical School in 1930.

Training in Neuropsychiatry and Allied Fields.—The Illinois State Department of Public Welfare announces a course of training in psychiatry and allied fields to fulfil the requirements of the American Psychiatric Association and to prepare the resident for the examination to become certified by the American Board of Psychiatry and Neurology. The regular positions in the state hospitals will be filled from the graduates of this course whenever possible. Opportunities include in the first year nine months' state hospital service and three months' resident service at the Illinois Neuropsychiatric Institute. While in the state hospital service the resident will work for at least three months each on the male and female receiving service under a competent psychiatrist. In the second year the resident will have nine months in state service and three months outside of state hospital service which will be spent at the Veterans' Rehabilitation Center, at the Psychopathic Hospital of Cook County, at a private hospital, at the Juvenile Court, at the Behavior Clinic of the Criminal Court or at the Municipal Psychiatric Institute. While at the state hospital the resident will be in charge of a service for the chronically afflicted under a competent psychiatrist. The didactic course offered in the first year will continue during this time. In the third year the resident will serve as physician one on the regular staff of a state hospital, taking care of the patients as the state hospital management may deem advisable. At the end of nine months he may be eligible for a special course in any of the institutions mentioned of his own choice. It is understood that any resident who enters training under this plan is to be accepted by a committee. This committee will probably consist of a representative from the state alienist's office, one from the central office of the department of public welfare and one member from the state hospital service. The representative from the alienist's office will also act as liaison officer between the department of public welfare and the various universities participating in the program. Preference will be shown to veterans of World War II. The salary for the first year will range from $150 to $200 a month, the second year $185 to $245 and the third year $310 to $360. Applicants should send their requests to Dr. Harry R. Hoffman, state alienist, Illinois Neuropsychiatric Institute, 912 South Wood Street, Chicago. The residencies start July 1.

KENTUCKY

Governor Vetoes Medical Scholarship Bill.—Governor Simeon S. Willis on March 26 vetoed a measure that would establish a revolving fund for scholarships to help prospective rural doctors through medical school and is reported to have said that although the rural medical care needs were great "we cannot at public expense violate the constitution." The bill would set up a $750,000 fund for loans to medical students in return for a given period of practice in rural areas. The governor is reported to have said that he could not sign the bill because the constitution forbids grants of money to persons prior to their performing a public service. The bill was the outgrowth of a plan inaugurated by the Kentucky State Medical Association (THE JOURNAL, January 19, p. 162). The program will continue, according to newspaper reports, since the project

has already been launched (THE JOURNAL, March 23, p. 804). The board of the state medical group administering the fund now has about $12,000, nearly all of which has come from doctors. It is estimated that from $30,000 to $40,000 is needed.

LOUISIANA

State Medical Meeting.—The Louisiana State Medical Society will hold its 1946 session at the Hotel Bentley, Alexandria, May 6-8, under the presidency of Dr. Valentine H. Fuchs, New Orleans. Dr. Bayard T. Horton, Rochester, Minn., the guest speaker, will discuss "Headache." At an open meeting Monday evening Mr. Jay Ketchum, director of the Division of Prepayment Medical Care Plans, American Medical Association, will discuss "Better Health the American Way." Included among other speakers will be:

Dr. Ralph V. Platou, New Orleans, Chronic Cough in Children.
Dr. James W. McLaurin, Baton Rouge, The Lempert Endoral Fenestration Operation for Clinical Otosclerosis.
Dr. Francis W. Raggio Jr., Lake Charles, The Management of Common Eye Injuries in the General Practitioner's Office.
Dr. Murrel H. Kaplan, New Orleans, Calcareous Pancreatic Disease.
Dr. Charles E. Dunlap, New Orleans, The Use of Biopsies in the Diagnosis of Tumors.
Dr. Calvin M. Johnson, New Orleans, Essential Factors in Preoperative, Operative and Postoperative Care in Gynecologic Patients.
Dr. Henry R. Kahle, New Orleans, Acute Craniocerebral Injury.
Dr. Lucien A. Fortier, New Orleans, Intravenous Pyelography as an Aid in Diagnosis.
Dr. Jesse R. Stamper, Shreveport, Plastic Operations for Urethral Strictures.
Drs. John Adriani and Ray T. Parmley, both of New Orleans, Saddle Spinal Anesthesia in Obstetrics.
Dr. Charles B. Odom, New Orleans, Civilian Application of Battle Casualty Experiences.
Dr. William A. Sodeman, New Orleans, Disease and the Aged.
Drs. Joe E. and Alice E. B. Holoubek, both of Shreveport, A Study of Heart Disease in the South.
Dr. Lyon K. Loomis, New Orleans, Some Common Errors in Fracture Treatment.
Dr. Charles S. Holbrook, New Orleans, Five Years' Experience with Electric Sleep (Electric Shock) Treatment.

The Louisiana Tuberculosis Association will devote its program at the Hotel Bentley, Alexandria, May 5, to a symposium on reconversion for tuberculosis control.

MICHIGAN

The Hickey Lecture.—Dr. Albert C. Furstenberg, dean, University of Michigan Medical School, Ann Arbor, gave the tenth Hickey Memorial Lecture before the Wayne County Medical Society, April 1. His subject was "The Management of Impaired Hearing in the General Practice of Medicine."

Physicians Resign in Protest to Welfare Board Appointment.—On March 18 the Detroit *Times* reported that four physicians had resigned from the staff of City of Detroit Receiving Hospital (Redford Branch) in protest against the reappointment of James E. Frazer to the city welfare commission. The physicians were Drs. Arthur G. Liddicoat, Louis J. Gariepy, Samuel A. Flaherty and Willard A. Chipman, all of Detroit. The newspaper reports indicated that a citizens committee had been appointed by Mayor Jeffries to investigate the administration and operation of the hospital and to determine the merits of controversies between Mr. Frazer and members of the staff of the hospital.

The State's Oldest Physician.—Dr. Homer Pease Mix, Riverside, 94 years of age, is Michigan's oldest physician. He once taught in rural schools. In 1880 Dr. Mix graduated at Hahnemann Medical School and Hospital, Chicago. He served an internship at Cook County Hospital and was licensed to practice in Illinois but shortly thereafter took over the practice of a deceased physician in Highland, Iowa County, Wis., where he later served as county physician. In 1908 Dr. Mix moved his family to Benton Harbor. In 1912 they went to Riverside, where the physician remained in active practice until 1945. The St. Joseph *Herald*, Oct. 12, 1931, stated that forty years of Dr. Mix's career had been spent as a health officer both in Wisconsin and in Michigan.

NEW JERSEY

Mabel Lesher Joins Social Hygiene Association.—Dr. Mabel Grier-Lesher, Camden, since 1927 medical inspector of the Camden public schools and a member of the faculty of Rutgers University School of Education, has been appointed educational consultant for field work for the American Social Hygiene Association. Dr. Lesher, who graduated at Johns Hopkins University School of Medicine, Baltimore, in 1905, has been chairman of the advisory committee of social hygiene education of the New Jersey State Department of Public Instruction and also social hygiene chairman of the New Jersey Congress of Parents and Teachers.

NEW YORK

Graduate Lectures.—Dr. George E. Anderson, Brooklyn, will address the Cortland County Medical Society, May 17, on "Diabetes Mellitus." Dr. Arnold Z. Pfeffer, New York City, will address the Oswego County Medical Society, May 8, at the Fulton Club, Fulton, on "Neuropsychiatric Aspects of Arteriosclerosis and Aging."

Charles Shields Named Commissioner of Health.—Col. Charles D. Shields, who recently returned from four years' service overseas, part of which was holding the position of chief public health officer in Bavaria, has been appointed commissioner of health of Buffalo. He will succeed Dr. Francis E. Fronczak, who is retiring after thirty-six years of service as commissioner of health of Buffalo. Dr. Fronczak plans to join the UNRRA in Poland as a medical lecturer and organizer of public health service. Dr. Shields graduated at the Georgetown University School of Medicine, Washington, and Harvard University School of Public Health, Boston.

One Hundred Years of Medicine at Buffalo.—On April 12-13 the University of Buffalo School of Medicine observed the one hundredth anniversary of its founding. Centennial exercises were held at the Hotel Statler, Buffalo, and included the following speakers:

Dr. Mitchell I. Rubin, Buffalo, Diseases of the Kidney: Newer Concepts, Including Treatment.
Dr. Lester R. Dragstedt, Chicago, Recent Developments in the Treatment of Peptic Ulcer.
Dr. Joseph Stokes Jr., Philadelphia, Infectious Hepatitis: Etiology, Prophylaxis and Treatment.
Dr. Edward F. Hartung, New York City, Newer Developments in the Treatment of Arthritis and Rheumatic Diseases.
Dr. Edward M. Bridge, Buffalo, The Management of the Epileptic Patient.
Dr. Carl E. Arbeaman, Buffalo, An Evaluation of New Drugs Used in the Treatment of Hay Fever, Asthma and Urticaria.
Dr. Samuel Proger, Boston, The Management of Anoxia: New Clinical Approach.
Dr. Chester S. Keefer, Boston, Penicillin and Streptomycin.
Dr. John E. Howard, Baltimore, The Management of the Convalescent Patient.
Dr. James F. Norton, Jersey City, N. J., Factors Influencing Maternal Risk.

At a banquet, Dr. Morris Fishbein, Chicago, Editor of THE JOURNAL, spoke on "American Medicine and the Health Program." In addition to addressing the centennial banquet, Dr. Fishbein gave a fifteen minute broadcast over WBEN on "Medicine in the Postwar World."

New York City

Otto Loewi Becomes Citizen.—Dr. Otto Loewi, winner of the Nobel Prize for medicine and physiology in 1936, became a United States citizen April 1. Dr. Loewi is research professor of pharmacology at the New York University College of Medicine.

First Appeal for Funds in Ninety-One Years.—The Woman's Hospital on April 1 opened a campaign for $100,000, its first public appeal for funds in ninety-one years. The hospital was established in 1855 under the direction of Dr. J. Marion Sims.

Counsel Named to Help with Office Space.—Joseph Platzker, former commissioner of the department of housing and buildings, has been appointed real estate counsel to the veterans service sponsored by the Medical Society of the County of New York. Mr. Platzker will assist members of the society who are returning from the armed forces in finding office space and residences.

Clinic for Fire Department.—It is planned to establish an outpatient clinic for members of the New York Fire Department and their families; $125,000 has been pledged by the department's honor emergency fund and is said to be the first appropriation of this kind in the fund's history. The clinic will be at Engine Company 30 at 278 Spring Street. The third floor of the fire house will be rearranged so that the equipment, including x-ray machines, a cardiograph, physical therapy and diathermy devices and a dental office will be set up with soundproof walls and ceilings, casement windows and air conditioning.

Dr. Enloe Named Medical Director.—Dr. Cortez F. Enloe Jr., who was recently released from military service, has become a partner in Murray Breese Associates, Inc., and has been appointed vice president and medical director of the agency. During his last year of service Dr. Enloe completed a mission for the Secretary of War as chief of the medical branch of the U. S. Strategic Bombing Survey. His report on "The Effect of Bombing on Health and Medical Care in Germany" was characterized by Secretary of War Robert P. Patterson as "vital in the planning for the defense of the health of this country."

Medallion Goes to Nathaniel Rathbun.—In tribute to his forty-eight years in medicine and his contributions in the field of urology, Dr. Nathaniel P. Rathbun was presented with the second alumni medallion for distinguished service to American medicine during the eighty-eighth commencement exercises at the Long Island College of Medicine, Brooklyn, at the Brooklyn Academy of Music, March 28. Dr. Rathbun graduated at Long Island College of Medicine in 1898. He was valedictorian of his class. He has been associated with the Brooklyn Hospital since 1898, first as intern, resigning as head of the urologic service June 1, 1946 but continuing as consulting urologist. The first alumni medallion for distinguished service to medicine was presented in 1944 to Dr. Robert L. Dickinson, gynecologist, who graduated in 1882.

OHIO

Course in Pediatrics and Obstetrics.—A refresher course in pediatrics and obstetrics will be given April 29-May 1 in Cleveland under the sponsorship of the Academy of Medicine of Cleveland, Western Reserve University School of Medicine, Cleveland, and the Cleveland division of health with the cooperation of the Anti-Tuberculosis League and the Cleveland Child Health Association. Among the speakers will be:

Dr. C. Anderson Aldrich, Rochester, Minn., Observations on Normal Behavior in Infants.
Dr. Donovan J. McCune, New York, Recognition and Treatment of Mental Defectiveness in Infants and Children.
Dr. James L. Wilson, Ann Arbor, Treatment of Acute Respiratory Diseases in Infants and Children.
Dr. Henry J. Gerstenberger, Cleveland, Vitamin Needs in Infancy.
Dr. Bruno Gebhard, Cleveland, Who Is Your Doctor?
Dr. Charles F. McKhann, Cleveland, Vomiting and Diarrhea in Infants.
Dr. Walter Heymann, Cleveland, Renal Disorders in Infants and Children.
Dr. Norman F. Miller, Ann Arbor, Should Mothers Nurse Their Babies?
Dr. John A. Toomey, Cleveland, Diagnosis and Treatment of Meningeal Irritation in Children.
Dr. Nicholson J. Eastman, Baltimore, A Review of Two Hundred Consultations in Private Obstetric Practice.
Dr. Borden S. Veeder, St. Louis, The Pediatrician Looks at Child Psychiatry.
Thomas Hill, D.D.S., Cleveland, Dental Health in Children.
Dr. Arthur J. Horesh, Cleveland, Allergy in Childhood.
Dr. John W. Holloway, Cleveland, The Management of Surgical Conditions in Infancy and Childhood.
Dr. Chauncey W. Wyckoff, Cleveland, Advances in Infant Feeding.
Miss Josephine Walker, Cleveland, A Concord of Sweet Sounds.

PENNSYLVANIA

Clinics for Crippled Children.—Thirty-seven diagnostic clinics for crippled children will be held in Pennsylvania during April, May and June under the auspices of the crippled children's division of the Pennsylvania Department of Health.

Million Dollar Gift to Hospital.—One million dollars has been given to the Reading Hospital by two citizens of Berks County, Ferdinand Thun and Henry Jansen, partners in the Berkshire Knitting Mills, who observed their eightieth birthdays in February. The only stipulation was that the money be used to expand the hospital.

Personal.—Dr. Carl O. Keck, Bethlehem, Pa., has been appointed director of the student health service of Lehigh University, Bethlehem, to succeed Dr. Raymond C. Bull, Bethlehem, Pa., who recently retired.——Ivor Griffith, Sc.D., president of the Philadelphia College of Pharmacy and Science, has been named a member of the advisory health board of the commonwealth of Pennsylvania by Governor Edward Martin. The appointment was made on March 13 and extends until the end of the next session of the state senate.

Philadelphia

Hospital News.—The name of the Home for Consumptives, located in Chestnut Hill, has been changed to All Saints' Hospital for Treatment of Tuberculosis.

The Heart and the School Child.—A symposium on the heart and the school child was held in the Administration Building April 15 under the division of medical services, school district of Philadelphia.

Personal.—Dr. Richard J. Campion, local medical officer of the Bell Telephone Company, has been appointed medical director of that company. He will now fill the duties of both offices. Dr. Campion succeeds Dr. George Morris Piersol, who retired last October on account of age.——Dr. Pascal F. Luchesi, head of the Philadelphia Hospital for Contagious Diseases since 1933 and recently released from service in the Army of the United States on assignment to the Health and Sanitation Division, Institute of Inter-American Affairs, in Uruguay, has been named superintendent and medical director of the Philadelphia General Hospital to succeed Dr. Ignatius S. Hneleski, who resigned, effective March 1, to return to private practice.

Educational Cancer Secretary.—Mr. Elno C. Nicodemus has resigned as associate regional executive of the Southwest region of the USO to become educational secretary of the Philadelphia division of the American Cancer Society, a newly created position. Mr. Nicodemus will be responsible for the division's program of expansion on the educational front, which will include education of the public from school children up in what is known today about the causes, prevention and treatment of cancer, its "danger signals" and the public's responsibilities in the cancer control program.

Pittsburgh

Personal.—Dr. J. Huber Wagner, president of the staff of St. Francis Hospital, has been appointed chief surgeon of the Carnegie-Illinois Steel Corporation to succeed Dr. William O'Neill Sherman, who retired after thirty-five years' service with the company. Dr. Wagner has been associated with the steel corporation since 1920.

SOUTH CAROLINA

State Medical Meeting.—The South Carolina Medical Association will hold a meeting April 30-May 2 at the Ocean Forest Hotel, Myrtle Beach, under the presidency of Dr. William T. Brockman, Greenville. The Greenville County Medical Society will be host. Among the speakers will be:

Dr. William H. Kelley, Charleston, Certain New Antihistamine Drugs.
Dr. Charles G. Spivey, Columbia, Splenosis.
Dr. John F. Rainey, Anderson, Meningococcemia.
Dr. Horace G. Smithy Jr., Charleston, The Application of Sympathetic Nerve Interruption to Organic Obstructive Vascular Disease.
Dr. Edward F. Parker, Charleston, The Treatment of Hemothorax and Its Complications in Thoracic Injuries.
Dr. Lawrence P. Thackston, Orangeburg, The Management of Urethral Calculi.
Dr. Furman T. Wallace, Spartanburg, The Management of Thyroidectomy Incisions.
Dr. Joseph I. Waring, Dr. Harold R. Pratt-Thomas and J. A. Richardson, Charleston, Kerosine Poisoning.
Dr. Dargan S. Pope, Columbia, Indications for Interruption of Pregnancy and Puerperal Sterilization.
Dr. Arthur L. Rivers, Charleston, Practical Suggestions for the Care of Obstetric Patients.

Special addresses will be given by Dr. Richard B. Cattell, Boston, on "Gallbladder Disease"; Dr. Louis J. Hirschman, Detroit, "Proctology in Childhood," and Dr. Francis Carter, Durham, "Premature Detachment of the Placenta."

WEST VIRGINIA

Personal.—Dr. Donald J. McNairy, U. S. Public Health Service, who has been in charge of the rapid treatment center in Norfolk, Va., has been assigned as medical officer in charge of the Kanawha Valley Medical Center at South Charleston. He succeeds Dr. Robert D. Wright, who was transferred to the U. S. Public Health Service Laboratory at Staten Island, N. Y. Since the establishment of the Kanawha Valley Medical Center on March 6, 1944 more than 6,000 patients have received treatment for syphilis, gonorrhea and other venereal infections.

Honorary Life Memberships.—The West Virginia State Medical Association recently conferred life memberships on:

Dr. Benjamin M. Stout, Morgantown.
Dr. William M. Riley, Lillybrook.
Dr. Robert Wriston, Beckley.
Dr. Ralph C. Mitchell, Sabine.
Dr. Lonzo E. Steele, Logan.
Dr. Charles L. Kinney, Idamay.
Dr. William E. Whiteside, Parsons.

WISCONSIN

Personal.—Dr. Joseph S. Evans, Madison, was awarded honorary membership in the Wisconsin Hospital Association February 15 "for devoted service to medical education and the care of the sick."

State Board Reorganized.—The Wisconsin State Board of Health has been reorganized to include five main sections to facilitate public health administration in the state. The board is now composed of sections on preventable disease, sanitary engineering, local health service, maternal and child health, and general administration. Dr. Allan A. Filek, Madison, is supervisor of the section on local health services (THE JOURNAL, March 16, p. 728). Dr. Harry M. Guilford, Madison, director of the bureau of communicable diseases, will direct the section on preventable disease and Dr. Amy L. Hunter, Madison, will continue to head the section on maternal and child health. L. M. Warrick is in charge of the section on sanitary engineering. One new division has been created under general administration. Known as central statistical services, it will have charge of tabulating and making available all statistics for the use of public health personnel in the state. Vivian Holland was appointed acting chief statistician.

GENERAL

The Science and Art of Medicine.—On April 16 the *Science and Art of Medicine* made its appearance. The new publication is being brought out by the Macmillan Company, 60 Fifth Avenue, New York 11.

Pharmaceutical Association to Meet.—The 1946 meetings of the American Pharmaceutical Association, American Association of Colleges of Pharmacy and the National Association of Boards of Pharmacy will be held at the Hotel William Penn, Pittsburgh, August 25-30. Additional information may be obtained from Robert P. Fischelis, Sc.D., secretary, American Pharmaceutical Association, 2215 Constitution Avenue, Washington D. C.

Grant for Record Librarians.—The National Foundation for Infantile Paralysis has granted $83,000 to the American Association of Medical Record Librarians to provide in-service training opportunities for record librarians now employed, and scholarships for training medical record librarians. The grant is effective July 1 for one year. The executive secretary of the American Association of Medical Record Librarians is Mrs. Adaline C. Hayden, 18 East Division Street, Chicago 10.

Prisoners Act as Guinea Pigs in Experiments.—Twenty-five convicts in San Quentin Penitentiary have volunteered to accept injections of the amounts of streptococcus virus weekly for three to six weeks in a test to see whether immunity to streptococcic infections and perhaps rheumatic fever might be attained through use of vaccines, according to the New York *Times*, March 28. Dr. Lowell A. Rantz, assistant professor of medicine, Stanford University School of Medicine, San Francisco, is directing the research. It was expected that the experiments would be started early in April.

Pamphlets on Occupational Health.—The American Foundation of Occupational Health, room 1300, 28 East Jackson Boulevard, Chicago 4, is publishing a series of pamphlets on industrial health. The first carries a report of the committee on medical education of the American Association of Industrial Physicians and Surgeons entitled "The Teaching of Occupational Medicine." The American Foundation of Occupational Health was established as a trust under the laws of Illinois on June 22, 1945 to aid in the study and teaching of problems pertaining to the practice of industrial and occupational medicine and surgery, including direct expenditure for such purpose; grants to universities and colleges; establishment of endowments; establishment of scholarship and fellowship funds, and the donation of fellowships and scholarships. The foundation also means to cooperate in the development of industrial and occupational medical service and education and to conduct field and consultation services. Officers of the foundation are automatically officers of the association (THE JOURNAL, April 20, p. 1184).

Dr. Goodpasture Receives Passano Award.—Dr. Ernest W. Goodpasture, professor of pathology and dean of the Vanderbilt University School of Medicine, Nashville, has been announced as the recipient of the 1946 Passano Foundation Award. Presentation of the $5,000 cash award will be made in the Osler Hall of the Medical and Chirurgical Faculty of Maryland, Baltimore, May 15. The award was created by the foundation, which was established in 1944 by the Williams and Wilkins Company, medical publishers of Baltimore, to aid in any way possible the advancement of medical research, especially research that bears promise of clinical application (THE JOURNAL, Feb. 19, 1944, p. 521; April 14, 1945, p. 1003). Dr. Goodpasture was selected for his "original development of the method for propagation of viruses in pure culture by inoculation of chick embryos and for his outstanding contributions to advancement of knowledge of the cell parasite relationship in bacterial and virus infection." Following the presentation of the award by Mr. Edward B. Passano, chairman of the board of the Williams and Wilkins Company, Dr. Goodpasture will deliver an address on "Research and Medical Practice."

CANADA

Executive Director for Public Health Association.—Dr. James H. Baillie, Toronto, recently in charge of hygiene and preventive medicine in the Directorate of Medical Services, Ottawa, has been appointed executive director of the Canadian Public Health Association, Toronto.

New Department of Anesthesia at McGill.—Dr. Wesley Bourne, Westmount, Que., is chairman of a newly created department of anesthesia at McGill University Faculty of Medicine, Montreal. Chief objectives of the new department are to improve the teaching of anesthesia to the undergraduate students in medicine, to increase the opportunities for learning anesthesia among the interns of the hospitals connected with the university, to conduct a three year diploma course in anesthesia and to develop investigation in anesthesia in the clinic and in the laboratory from the point of view of interrelationship and in an interdependent fashion with the other departments of the university.

FOREIGN

New Medical Journal.—The first issue of *Clinica Nuova* recently appeared. Drs. M. Coppo and N. Aliotta are editor and assistant editor, respectively. This is a bimonthly Italian journal with headquarters at Viale 21 Aprile, 13, Rome. Price of subscription for one year is 360 lire (72 cents). Correspondence is to be sent to Casella Postal 164, Rome. The first issue contains sections of original articles, clinical notes, queries and minor notes, current medical literature and medical news.

Arab Medical Group Publishes Journal.—The *Journal of the Palestine Arab Medical Association* recently made its appearance. It is published in Jerusalem by the Palestine Arab Medical Association at the Economic Press, Jerusalem. Dr. M. T. Dajani, Jerusalem, is the editor. The journal is to be issued bimonthly in the Arabic and English languages. All communications should be addressed to the editors of the Journal of the Palestine Arab Medical Association, Mamilla Road 36, Jerusalem, Palestine.

David Anderson-Berry Prize.—A David Anderson-Berry silver-gilt medal, together with a sum of money amounting to about £100, will be awarded in 1947 by the Royal Society of Edinburgh to the person who, in the opinion of the council, has recently produced the best work on the therapeutic effect of x-rays on human diseases. Applications for this prize are invited. They may be based on both published and unpublished work and should be accompanied by copies of relevant papers. Applications must be in the hands of the General Secretary, Royal Society of Edinburgh, 22 George Street, Edinburgh 2, by December 1.

Swiss Hospital Opened.—On Sept. 29, 1945 the remodeled Burger Hospital, Basle, Switzerland, was formally opened. The hospital was established in 1842. Through the years four new building projects proved unsuccessful. In 1939 a building commission was formed with Dr. Moser, director of the Burger Hospital, as head. The preliminary demolition work was completed when World War II broke out. In 1940 a first aid station with medical service for war victims was opened; on Oct. 4, 1941 a foundation stone was laid for the first principal units of the renovated hospital comprising the huge main part of the new hospital, the so-called "house of beds" and the "treatment building." Five bridgelike connections form a link between the "treatment building" and the "house of beds." Operating rooms, emergency rooms, clinics, all treatment rooms, laboratories and the administration and reception offices are housed in the "treatment building," which has three floors and two auditoriums. On the ground floor of the "house of beds" are the installations for x-ray, diagnosis and physical medicine, while the first, second, third and fourth floors contain wards for both men and women. A second medical and a second surgical section with its own operating rooms are featured on the fifth floor. On the sixth floor of this "house of beds" are rooms for 2 patients each and on the seventh floor are single rooms with balconies. A building for patients suffering from contagious diseases forms part of the second construction stage, with completion due this spring. After this the parts remaining of the old Burger Hospital will gradually be modernized.

Government Services

Causes of Sudden Death

Dr. Alan R. Moritz, professor of legal medicine, Harvard Medical School, Boston, and honorary consultant to the Army Medical Library, and Capt. Norman Zamcheck of the medicolegal pathology division of the Army Institute of Pathology, are making a study of sudden death within the military age group. A selected list of ninety-two recent books and periodical references, a portion of the bibliography for this project, has been compiled by the reference division and comprises material in all languages published mainly since 1940. According to the *Army Medical Library News* the study deals with sudden deaths due to natural causes, the majority due to coronary artery disease, intracranial hemorrhage, meningococcic infection, miscellaneous causes and causes undetermined. To date approximately 500 cases are involved. It is expected that this project will be finished within a few months, the results to be published both separately and as a section in the history of the Army Medical Department of World War II.

Deaths

Walter Edward Dandy ✠ celebrated specialist in neurology, died at the Johns Hopkins Hospital, Baltimore, April 19, of coronary occlusion, aged 60.

Dr. Dandy was born in Sedalia, Mo., April 6, 1886. He graduated at the University of Missouri in 1907 and Johns Hopkins University School of Medicine, Baltimore, in 1910. After his internship at Johns Hopkins Hospital he entered private practice in Baltimore.

He was a member of the founders group of the American Board of Surgery, a specialist certified by the American Board of Neurological Surgery and held memberships in various groups, including the American and Southern surgical associations and the American Neurological Association. He was also a fellow of the American College of Surgeons.

For many years Dr. Dandy had been a member of the staff of Johns Hopkins, serving latterly as adjunct professor of neurologic surgery in charge of surgery of the nervous system. It was in this field that he had contributed noted technics, particularly in surgery of the brain. He had introduced new operative procedures for tumors and aneurysms of the brain, for hydrocephalus and for neuralgias and other disturbances of cranial nerves; discovered ruptured intervertebral disks which cause low backaches and sciatica and introduced surgical procedure for their cure. Possibly it may be said that his major contribution was in the field of ventriculography, ventricular estimation and cerebral pneumography for diagnosis and localization of tumors of the brain and intracranial lesions.

Frank Manly Fuller ✠ Keokuk, Iowa; Keokuk Medical College, 1897; born in Keokuk, Sept. 29, 1868; served as president and vice president of the Federation of State Medical Boards of the United States, chairman, secretary and member of the state board of medical examiners, president of the Iowa State Medical Society, of which he had been a life member, Lee County Medical Society, Iowa Clinical Medical Society, Southeastern Iowa Medical Society and the Des Moines Valley Medical Society; fellow of the American College of Physicians; formerly professor of chemistry and clinical diseases of children at his alma mater; for eight years a member of company A of the Iowa National Guard; a captain in the medical corps of the U. S. Army, serving overseas during World War I; specialist certified by the American Board of Internal Medicine; served the city as alderman and as physician to the board of health; for many years on the staffs of the Graham Protestant Hospital and St. Joseph's Hospital, where he died March 19, aged 77.

John Matthews Peters ✠ Providence, R. I.; Harvard Medical School, Boston, 1887; born in Syracuse, N. Y., Nov. 2, 1863; served an internship at the Rhode Island Hospital, where he had been superintendent from 1889 to 1934, when he became superintendent emeritus; presented to the hospital the Charlotte Brooks Peters Library in memory of his wife; the "Peters House," a home for interns, was named for him; past president of the American Hospital Association, New England Hospital Association, Rhode Island Medical Society and Providence Medical Society; since 1909, the year of its creation, had been a member of the Providence Board of Hospital Commissioners; in 1931 awarded the honorary degree of master of arts by Brown University; died in the Butler Hospital January 27, aged 82, of bronchopneumonia and cardiovascular renal disease.

Mat Bloomfield ✠ Joliet, Ill.; Rush Medical College, Chicago, 1912; born in Toledo, Ill., Dec. 25, 1887; fellow of the American College of Surgeons; president of the Will County Tuberculosis Association; past president of the Will-Grundy Counties Medical Society; physician for Selective Service Board number 1 during World Wars I and II; clinical instructor of obstetrics and gynecology at the University of Illinois College of Medicine, Chicago; surgeon, Illinois State Penitentiary at Stateville, the Elgin, Joliet and Eastern Railroad, the New York Central Railroad and the Carnegie-Illinois Steel Plant; physician and surgeon for the Joliet Township High School; on the staff of St. Joseph's Hospital; chief of staff of the Silver Cross Hospital; died January 6, aged 58, of carcinoma of the liver.

Harry Varsil Hubbard ✠ Plainfield, N. J.; University of Vermont College of Medicine, Burlington, 1898; born in Rochester, Vt., Sept. 14, 1873; formerly associate professor of ophthalmology at the New York Post-Graduate Medical School and Hospital in New York; past president of the Union County Medical Society; for a term vice president of the American Medical Golfing Association; served during World War I; director of the Plainfield Savings Bank; consulting surgeon, Somerset Hospital, Somerville; for many years medical director of the Muhlenberg Hospital, where he was attending surgeon of the eye, ear, nose and throat department and consulting surgeon and where he died January 30, aged 72, of cerebral thrombosis and coronary thrombosis.

James Owen Howells ✠ Bridgeport, Ohio; University of Pennsylvania Department of Medicine, Philadelphia, 1894; born in Haverfordwest, Wales, Feb. 17, 1863; fellow of the American College of Surgeons; also a graduate in pharmacy; member and at one time president of the Association of Baltimore and Ohio Railroad Surgeons; past president of the Belmont County Medical Society; for many years a member of the board of education; at one time a member of the staff of the Ohio Valley General Hospital at Wheeling, W. Va.; served as a member of the board of directors of the Belmont Sanatorium in St. Clairsville; died in Little Rock, Ark., January 4, aged 82, following an operation for carcinoma of the transverse colon.

William Russell Eastman ✠ Colonel, U. S. Army, retired, La Jolla, Calif.; Columbian University Medical Department, Washington, D. C., 1901; Army Medical School, 1902; fellow of the American College of Surgeons; entered the regular army in 1901; promoted through the various grades to that of lieutenant colonel in 1917 and retired in the same rank Dec. 15, 1922 for disability in line of duty; for meritorious service during World War I was awarded a citation from General Pershing; promoted to the rank of colonel, retired, under the Act of June 21, 1930; associated with the Scripps Memorial Hospital; died in the U. S. Naval Hospital, San Diego, December 28, aged 72, of cerebrovascular disease.

Donald Blair Lowe ✠ Akron, Ohio; Western Reserve University Medical Department, Cleveland, 1912; born in Kingsville, Ohio, Aug. 1, 1883; formerly instructor of medicine at his alma mater; joined the U. S. Public Health Service in 1914; past president of the Summit County Medical Society and the American Association of Industrial Physicians and Surgeons; member of the American Public Health Association; fellow of the American College of Physicians; in August 1915 named medical director of the B. F. Goodrich Company; member and in 1936 chief of staff of the City Hospital, where he died March 2, aged 62, of acute pancreatitis.

Edwin Atkins Merritt ✠ Washington, D. C.; University of Nebraska College of Medicine, Omaha, 1904; clinical professor of radiology at the Georgetown University School of Medicine; specialist certified by the American Board of Radiology; member of the American Roentgen Ray Society; served during the Spanish-American and World wars; delivered the second Davidson Foundation Lecture in October 1933; director of the Warwick Memorial Cancer Clinic; radiologist at the Garfield Memorial Hospital; served as consultant at the Veterans Administration Facility and as consultant and member of the national advisory council, U. S. Veterans Bureau; died in St. Petersburg, Fla., April 9, aged 66.

Elmer Maurice Smith ✠ Mount Vernon, Ill.; Medical College of Indiana, Indianapolis, 1889; born on July 5, 1868; served as radiologist overseas for eighteen months in World War I with rank of major in the medical corps of the U. S. Army; radiologist at the Mount Vernon Hospital from 1925 to 1942 and the Good Samaritan Hospital until January 1946; at one time associated with the U. S. Public Health Service Reserve; member of the International Congress of Radiology; in 1939 admitted into the fifty year club of the state medical society; died March 7, aged 77, of coronary thrombosis.

Albert Allen Alleyne, Atlantic City, N. J.; Howard University College of Medicine, Washington, D. C., 1915; served as city physician; died January 9, aged 63, of carcinoma of the liver and colon.

Anastasios Stavros Bacalis, Detroit; National University of Athens School of Medicine, Greece, 1917; died January 23, aged 53.

Oscar Baer ✠ Niagara Falls, N. Y.; New York Homeopathic Medical College and Hospital, New York, 1911; past president of the Niagara Falls Academy of Medicine and the Niagara County Medical Society; member of the staff of the Mount St. Mary's Hospital; chief of obstetrics and for a time served as head of the medical staff of the Memorial Hospital, where he died December 30, aged 67, of congestive heart failure and hypertension.

Adolphus Edmund Bertling ✠ Chicago; Rush Medical College, Chicago, 1895; an Affiliate Fellow of the American Medical Association; at one time associate professor of genitourinary diseases at the Illinois Post-Graduate Medical School; served on the staffs of the West Side and Frances Willard hospitals; died in the West Suburban Hospital, Oak Park, January 6, aged 80, of coronary occlusion.

Caesar Cassano, Elmhurst, N. Y.; New York University College of Medicine, 1939; member of the American Medical Association; also a graduate in pharmacy; served an internship and residency at the New York City Hospital, Welfare Island; formerly associated with the Kings County Hospital in Brooklyn and the Manhattan General Hospital; died recently aged 36.

Richard H. Cobb, Franklin, Va.; Memphis (Tenn.) Hospital Medical College, 1883; member of the American Medical Association; for many years member of the school board and town council; died January 3, aged 82, of cerebral hemorrhage.

Harold John Cooper ✠ Fresno, Calif.; Stanford University School of Medicine, San Francisco, 1921; in 1930 appointed medical director of the aeronautics branch of the department of commerce; began active duty as a major in the medical corps, Army of the United States, in May 1941 and service terminated in December 1941; died recently aged 51.

Edward Joseph Deibert ✠ Hellertown, Pa.; Medico-Chirurgical College of Philadelphia, 1911; on the staff of St. Luke's Hospital, Bethlehem; died January 3, aged 61, of cerebral thrombosis.

Ernest Dickey, Rockville Centre, N. Y.; McGill University Faculty of Medicine, Montreal, Que., Canada, 1922; on the staffs of the Meadowbrook Hospital, Hempstead, Nassau Hospital, Mineola, and the Mercy and South Nassau hospitals; member of the American Medical Association; died December 23, aged 50, of coronary thrombosis.

Samuel L. Diven, Carlisle, Pa.; University of Pennsylvania Department of Medicine, Philadelphia, 1884; formerly a member of the board of health and county coroner; died December 25, aged 90, of myocardial failure.

James William Eckford, Starkville, Miss.; Medical Department of Tulane University of Louisiana, New Orleans, 1896; died in the Doster Hospital, Columbus, January 5, aged 72, of coronary occlusion.

William James Fenelon, Ripon, Wis.; Rush Medical College, Chicago, 1894; died December 29, aged 80, of cardipvascular renal disease.

Daniel Sebastian Fisher ✠ Hughesville, Md.; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1921; served as health officer of Charles County and as chief of staff of the Physicians Memorial Hospital in La Plata; died in the University Hospital, Baltimore, January 5, aged 53, of coronary thrombosis.

Vern William Graham ✠ Corry, Pa.; Jefferson Medical College of Philadelphia, 1915; member of the civil service board; interned at the Hamot Hospital in Erie; associated with the Corry Hospital; died January 10, aged 58, of cardiac decompensation.

Paul Lincoln Greene ✠ Livingston, Mont.; Drake University College of Medicine, Des Moines, 1909; served during World War I; captain, National Guard, not on active duty; served as mayor of Livingston and as chief surgeon of the Northern Pacific Beneficial Association Hospital, Missoula, where he died January 5, aged 60, of carcinoma.

John Livermore Hazen ✠ Brockport, N. Y.; University of Buffalo School of Medicine, 1898; born in 1876; past president of the New York and New England Association of Railway Surgeons and of the Association of Surgeons for the New York Central System; served as physician at Brockport State Teachers College; health officer; for many years coroner's physician for western Monroe County; formerly welfare physician for the towns of Sweden, Clarkson and Hamlin; died January 10, aged 69, of cardiac decompensation.

Edward Sterling Hodgskin, Rockville Centre, N. Y.; College of Physicians and Surgeons, medical department of Columbia College, New York, 1893; for many years practiced in Brooklyn, where he was on the staff of the Midwood Hospital; died in the Meadowbrook Hospital, Hempstead, December 30, aged 75, of multiple sclerosis.

Lysle Clarence Howe ✠ Muscatine, Iowa; Keokuk Medical College, College of Physicians and Surgeons, 1903; died in the University Hospitals, Iowa City, in January, aged 68, of injuries received in an automobile accident.

Mae Christina Joyce, Bancroft, Mich.; Saginaw Valley Medical College, Saginaw, 1902; died in the Memorial Hospital, Owosso, January 17, aged 70, of an injury received in a fall.

Wallace D. Kennedy, Metter, Ga.; University of Georgia Medical Department, Augusta, 1891; member of the American Medical Association; served as a member of the city council and as state senator; part owner and medical director of the Kennedy Memorial Hospital, where he died December 28, aged 73, of carcinoma of the stomach.

William Amadeus Langsteen, Denver; Medizinische Fakultät der Universität Wien, Vienna, Austria, 1923; diplomate of the National Board of Medical Examiners; served a residency at the Colorado State Hospital, Pueblo; interned at the St. Anthony's Hospital, where he died December 21, aged 46, of pneumonia.

Lawrence Levy, Garden City, N. Y.; Ludwig-Maximilians-Universität Medizinische Fakultät, Munich, Bavaria, Germany, 1898; member of the American Medical Association; died December 31, aged 70, of coronary occlusion.

William Byron Lingard, Chicago; Chicago College of Medicine and Surgery, 1913; member of the American Medical Association; found dead January 13, aged 63.

Joseph Jerome Livingston, Tyler, Texas; Medical Department of Tulane University of Louisiana, New Orleans, 1910; served overseas during World War I; died recently, aged 70, of heart disease.

Edward Christopher McDaniel, Tyronza, Ark.; St. Louis College of Physicians and Surgeons, 1901; member of the American Medical Association; honorary member of the Arkansas Medical Society; in 1916 vice president of the Tri-State Medical Society; died January 4, aged 71, of cerebral hemorrhage.

Thomas Roy McLellan, Aliceville, Ala.; Memphis (Tenn.) Hospital Medical College, 1903; member of the American Medical Association; died in the Doster Hospital, Columbus, December 20, aged 69, of meningitis.

John William McMahan, Bedford, Ky.; University of Louisville Medical Department, 1893; died December 27, aged 80, of arteriosclerosic heart disease.

John Franklin Noyes, American Fork, Utah; University of Louisville Medical Department, 1894; died December 8, aged 83, of carcinoma of the prostate.

Roe Bernard Reed, Clearfield, Iowa; State University of Iowa College of Medicine, Iowa City, 1927; interned at St. Mary's Hospital, Kansas City, Mo.; member of the American Medical Association; city health officer; on the staff of the Decatur County Hospital, Leon; died December 20, aged 44, of angina pectoris.

Mason William Ross ✠ Brooklyn; Long Island College Hospital, Brooklyn, 1921; on the staff of the Bay Ridge Hospital; died January 7, aged 49, from carbon monoxide poisoning.

John H. Sandel, Danville, Pa.; Hahnemann Medical College of Philadelphia, 1882; member of the American Medical Association; for many years secretary of the Montour County Medical Society; died in the Danville State Hospital December 13, aged 91, of arteriosclerosis.

John Stephen Scott, Boston (licensed in Massachusetts in 1911); died recently, aged 76, of myocardial infarction.

Ray Hammond Shattuck, Boston; Middlesex College of Medicine and Surgery, Cambridge, 1920; died in the City Hospital January 2, aged 54, of cerebral sclerosis.

George Emerson Simpson ✠ Indiana, Pa.; Medical Department of the Western University of Pennsylvania, Pittsburgh, 1894; fellow of the American College of Surgeons; chief of the surgical staff, Indiana Hospital; vice president of the First National Bank; died January 2, aged 76, of coronary heart disease.

Thaddeus Warsaw Stephens, Chicago; Meharry Medical College, Nashville, Tenn., 1901; died December 20, aged about 70, of carcinoma of the prostate.

Harry Hill Van Kirk ✠ Lieutenant Colonel, U. S. Army, retired, Delaware, Ohio; Starling Medical College, Columbus, 1898; retired Oct. 31, 1932 at his own request after thirty years' service; formerly professor of military science and tactics at Western Reserve University School of Medicine, Cleveland, and assistant professor of military science and tactics at Ohio State University College of Medicine in Columbus; died in the Fort Hayes Hospital January 3, aged 73, of arteriosclerosis.

Charles Martel Werts ✠ Des Moines; State University of Iowa College of Medicine, Iowa City, 1902; fellow of the American College of Surgeons; served as lecturer and clinical instructor at the Drake University College of Medicine; on the staffs of the Iowa Methodist and Iowa Lutheran hospitals; died January 4, aged 69, of leukemia.

David Wilson ✠ Amsterdam, N. Y.; Cornell University Medical College, New York, 1907; died December 29, aged 61, of carcinoma of the stomach.

James William Wilson, Clearwater, Fla.; Bellevue Hospital Medical College, New York, 1880; died December 29, aged 88, of congestive heart failure and arteriosclerosis.

Foreign Letters

LONDON

(From Our Regular Correspondent)

March 30, 1946.

The British Medical Association and the National Health Service Bill

The British Medical Association has started an active campaign against the national health service bill. A mass meeting of the practitioners of Surrey, which includes a large part of South London, was addressed by Dr. Charles Hill, secretary of the British Medical Association. He said that the profession had for a long time pleaded for improvement and extension of health facilities and that some of the proposals in the bill were good, such as the organization of the hospitals on a regional basis. The proposals should be measured first by the public interest and second by the principles which had guided the profession in the formulation of its policy. Beneath those principles there was a firm determination to resist the conversion of the profession into a technical branch of central or local government. This would divide loyalties between patients and the body, state or other, which employed and directed the physicians. Although there were not naked proposals for whole time salaried service under the state, the question was whether the proposals contained the germ of such a service. The minister of health proposed to abolish the buying and selling of practices with compensation of the present owners. However, this buying and selling was the basis for the voluntary distribution of practitioners, and its abolition would mean a system of posting, placing and appointing general practitioners in the future. Again, the proposal to remunerate the practitioner largely by salary was likely to lead sooner or later to his becoming a wholly salaried officer of the state. The government by its majority might carry these proposals. Then the profession must do its utmost to present its point of view to all fair minded people in all parties. The one hope was to convince the public that the proposals were not in their interest. A movement toward a whole time salaried service meant a crisis in the history of the profession. The government could legislate, but without the cooperation of the profession there would be no service. A decision on this would have to be taken, but not until the bill had become an act.

F.R.S. Conferred on Five Members of the Medical Profession

The coveted distinction of F.R.S., which is an unequivocal mark of scientific eminence, has been conferred on five members of the medical profession: Dr. G. R. Cameron, professor of morbid anatomy at University College Hospital and assistant editor of the *Journal of Pathology and Bacteriology*, who has done research during the war for the government, including investigations on the effects of blast and on the local absorption of toxic substances, such as tannic acid. Brig. J. A. Sinton, V.C., of the Indian Medical Service, formerly director of the Malaria Survey of India, who retired in 1938 but returned to official service during the war, in which his exceptional knowledge of malaria and its transmission proved of great value. Dr. J. W. Trevan, director of the Wellcome Physiological Research Laboratories, who has made important investigations in the use of a wide variety of drugs. Dr. G. L. Brown of the National Institute for Medical Research, who took part before the war in the work initiated by Dale on the transmission of nerve impulses. The Royal Society has also conferred its fellowship on eminent clinicians, including Dr. F. M. R. Walshe, physician to the National Hospital, Queen Square, chief of the Neurological Department, University College Hospital, and editor of *Brain*.

Tubocurarine Chloride in Anesthesia

The use of tubocurarine in anesthesia was discussed at a recent meeting of the Section of Anesthetics of the Royal Society of Medicine. Dr. T. Cecil Gray pointed out that in this centenary of Morton's discovery a new advance has been made which may prove to be equally significant. The possibilities of tubocurarine were not realized until April 1945, when the crystallized extract was prepared from curare by Burroughs Wellcome. Recent work has suggested that muscular relaxation is produced by preventing the action of acetylcholine at the neuromuscular junction. In clinical use no effects on the electrocardiogram have been observed, but further investigation is required. Laryngeal and bronchial reflexes are depressed, preventing spasm.

Dr. John Halton reported the use of tubocurarine in 1,040 thoracic surgical cases, with 2 deaths which might have been attributed to the anesthetic. The disadvantages of pentothal alone were avoided (frequent cough and laryngeal spasm). The author has used 1.1 Gm. of pentothal and 25 mg. of tubocurarine with oxygen supplied in a closed circuit. The method is commended because of rapid induction with absence of spasm, ease of control, quick recovery and uneventful convalescence. There appears to be a synergism between the barbiturates and tubocurarine. The drug is not an anesthetic. Postoperative complications are lessened and the well-being of patients postoperatively is improved. The drug is powerful and safe but should not be used in the presence of extensive renal damage.

THE NETHERLANDS

(From Our Regular Correspondent)

AMSTERDAM, March 24, 1946.

Blood Dialysis as a Method of Treatment for Uremic and Anuric Conditions

In a dissertation, to be published in the *Archives néerlandaises de physiologie* and in a paper in the *Nederlandsch tijdschrift voor geneeskunde*, W. J. Kolff describes his method of treatment of toxemic patients. It consists in cannulation of the radial artery and a vein, after heparinization. The blood is led through a dialyzing system, carefully kept at body temperature, and back to the organism. The apparatus requires 500 cc. of blood in order to be filled. The dialyzing surface amounts to 24,000 cc. In fourteen hours' passage of blood through such an artificial kidney, 250 Gm. of urea was eliminated from 120 Kg. of blood passed through the system. The manipulation can be repeated at intervals of four to six days. In addition to urea, uric acid, creatinine and indoxyl are eliminated from blood by the procedure. Patients in a hopeless condition were chosen for testing the method. The ultimate results were less satisfactory than they might have been with patients in a better condition. However, great relief was achieved for a few days, which might have offered a chance for eventual recovery instead of death in uremia. At the end of the actual dialyzing process the cannulas were left in situ for twenty-four hours, while the attachment to the apparatus was interrupted by screw clips. Blood sampling and transfusion could be done during this period. The cannulas were removed when the coagulability of the blood had returned to its normal level.

Hunger Osteopathia (Osteomalacia) in The Netherlands

A syndrome similar to that described in central Europe during 1918-1919 occurred in this country during 1943-1945. A report of Pompen, la Chapelle, Groen and Mercx comprises 24 cases of osteopathia, 22 in women. This sex distribution is ascribed to sex linked eating habits rather than to other sex differences. All case histories include diets deficient in calcium, phosphorus, fat and animal protein and lack of vitamin D. Moreover, all the patients lived indoors for a long time, several

of them in convents. The 2 men were Jews, forced to hide for years and subsisting on scanty food. Symptoms resemble rheumatism, with back ache and painful extremities manifested early by difficulty in climbing stairs and later by inability to move rapidly or to use the arms and legs normally. The muscles are painful. Signs of the disease include transverse bands or notches of diminished x-ray opacity in the long bones and pelvis, indicating abnormal skeletal reaction to normal use. Fractures are prone to occur. Earlier cases were observed in which bone changes had not occurred but in which symptoms and response to treatment were suggestive of hunger osteopathia. In addition to malnutrition and lack of actinic influences, middle age, exercise and sex definitely contribute to the incidence. Treatment consisted in initial confinement to bed and a diet to which animal protein and calcium as well as vitamin D were added. Injection of the latter may be necessary. Recovery usually occurred within two weeks, and x-ray findings disappeared in two months. The similarity with peacetime complaints of obscure etiology and significance may eventually draw attention to malnutrition and to therapeutic measures on similar lines as those whose value is now proved by the cases of hunger osteopathia. This report will appear in a Scandinavian medical journal and in the *Acta brevia Neerlandica*.

Other Forms of Starvation Disease

Formijne and van Eck (*Nederlandsch tijdschr. v. geneesk.*, 1945, No. 15, p. 164) draw attention to a similarity between starvation edema and that due to glomerulonephritis. The eyelids are often swollen, and blood albumin is decreased, though less constantly and seriously than would be expected. There is no albuminuria. In two later issues (numbers 18 and 19) of the same journal Formijne Drukker and van Loghem further contribute to the same subject by stating that hypoalbuminemia is very inconstant, venous pressure is not increased and fluid from edematous tissue has a low protein level. Various aspects of metabolism and digestion are disturbed in starvation disease, including anemia, hemorrhagic diathesis, cutaneous changes such as yellow nails, pigmentation, a kind of pellagra, decreased coagulability of the blood, bradycardia and very low body temperatures. One patient with an admission rectal temperature of 80.4 F. was warmed by hot water bottles to 85.4 F. but died nevertheless. Sudden death is not infrequent in these cases. Therapy consisted in rest, warmth and increased protein and butter rations. No hydrolyzed protein was used. The number of calories given per day was slowly increased from 1,600 to 2,500. No especial avitaminosis was observed.

Leiden University

The 371st anniversary of the founding of Holland's oldest university occurred on February 8. This was the first anniversary meeting to be held since the liberation. During the last years of German occupation the university was closed because the staff as a whole resisted attempts to transform the institution into a center of nazi education. Queen Wilhelmina gave an address in honor of the professors and members of staff who headed the resistance. Announcement was made by the rector, Professor B. G. Escher, that the senate would offer an honorary degree of Doctor of Leiden University to Mr. Winston Churchill.

Meeting of Biochemical Society

The first postwar meeting of the Biochemical Society on February 16 was devoted to a review of the progress in the Allied countries in research nutrition, tuberculosis, thyrotoxicosis and malaria.

The Supply of Penicillin

There is too little penicillin available for urgent needs. The causes of this shortage are not clear, but it is obvious that its effects are disastrous for those whose life depends on it.

ITALY

(From Our Regular Correspondent)

March 5, 1946.

Medical Lectures

Dr. Andre Le Renard of the Pasteur Institute of Paris recently gave lectures at a number of Italian universities. Dr. Renard was chief of the military sanitary center in North Africa during the war prior to appointment as director of the sanitary services of French troops in Italy. He discussed the mechanism of transformation of toxin into anatoxin in the preparation of vaccines. Formaldehyde, with increase in temperature and concentration, in the presence of amino acids shows a decreasing affinity for tryptophan, tyrosine, cysteine and phenylamine and still less affinity for serines, glutamic acid, leucine and alanine. Affinity decreases gradually, but the toxin retains part of its toxicity as long as its affinity to amino acids is decreasing. When chemical stability is established, toxin is transformed into anatoxin. Natural protein antigens (microbes, toxins and cells) have individual chemical actions during the processes of immunization and infection. Pathogenic toxins are complexes of amino acids. In the presence of formaldehyde, increasing in temperature and concentration, these substances attack the amino acids with resultant loss of capacity for fixation of toxin for proteins, but with preservation of the capacity of seizing the acids of the right chains. In this way the toxin loses its power of fixation but retains its antigenic structure. Consequently, through integral fixation on the antibody, the toxin is transformed into anatoxin. This explains an occurrence of ten years ago. A diphtheria anatoxin was marketed which had been prepared by serotherapeutic institutions in Piedmont and Lombardy. Many cases of diphtheria with high mortality occurred among vaccinated children. The laboratories were exonerated, but the heads of the institutions were put in jail by Mussolini. Exaggerations in the daily press resulted in a spreading fear of vaccination. It is apparent that the anatoxin which was empirically disintoxicated for laboratory animals had not reached the proper level of chemical stability, and consequently the transformation of toxin into anatoxin had not occurred.

Recent Progress

Recent progress in Italy includes the production of antibiotics in industrial centers in Rome and Siena and the preparation and publication of important books on obstetrics, cardiology and electrocardiology. In a book on erythremic diseases Dr. Di Guglielmo discusses the diagnosis and the differentiation of chronic polycythemia vera and acute and chronic erythremic myelosis. A differential character of polycythemia is that maturation of erythrocytes is complete, whereas maturity of the erythrocytes is not reached in erythremic myelosis. The therapy and prognosis of these diseases are different. Radioactive phosphorus is indicated in chronic polycythemia vera.

Marriages

Richard George McManus, New Rochelle, N. Y., to Miss Marjorie Alberta Andresen of Brooklyn, March 2.

Edward O. Loxterkamp to Miss Rosemary Grellner, both of St. Louis, in Clayton, Mo., January 26.

Richard Anderson Michaux to Miss Julia Gray Saunders, both of Richmond, Va., December 8.

Luis Carlos Prieto Jr., St. Louis, to Miss Helen Hunter Rhodes of Mobile, Ala., March 2.

William David Pace to Miss Maxine Charlier, both of Salt Lake City, March 12.

Joseph C. Presti, Baltimore, to Miss Angelina Alioto of San Francisco, February 2.

Herbert Leon Newbold Jr. to Miss Susan Rebecca Greison, both of Chicago, March 8.

Correspondence

THE SMALLPOX SITUATION IN SAN FRANCISCO

To the Editor:—Previous to January 1946 cases of smallpox had been absent for some years from the disease reports in San Francisco, the date of the last case being reported Jan. 6, 1939.

On Jan. 2, 1946 a case of smallpox was reported from an army hospital located in San Francisco. The patient left Japan on Dec. 21, 1945 by airplane, and the record indicates that he was suffering from a nasal pharyngitis; he arrived in Honolulu December 25 and was diagnosed as having influenza; he arrived at Hamilton Field, near San Francisco, the evening of December 27 and was transferred to an army hospital in San Francisco December 28 with the diagnosis of influenza-pneumonia. A rash appeared December 29 and the patient was placed in isolation December 30, the final diagnosis being smallpox on December 31. The patient was transferred to a second army hospital in San Francisco. The record further reports no visible vaccination scar.

The second, and first local, case was reported to and diagnosed as smallpox by the health department on Jan. 21, 1946. It is of epidemiologic interest to note that the patient resides within a block of the army hospital where the original patient was isolated and treated, that the onset was January 15, the rash appearing on January 19, that living in the same apartment house with this patient are numerous employees of the army hospital housing the original smallpox patient, that no direct contact with him can be definitely ascertained epidemiologically and that this patient showed no vaccination scar or had left San Francisco for some time previous to the onset of smallpox.

The third, and second local, case occurred in a Negro child who had not been vaccinated against smallpox at a university clinic where he was under treatment for asthma, presumably because of the bronchial asthma. It is of epidemiologic interest that this patient had been in the San Francisco Hospital of the Department of Public Health from January 26 to January 31 on account of bronchial asthma, that the pediatric ward in which this patient was confined with bronchial asthma was directly above local case 2 and that the rash appearing February 14 is epidemiologically suggestive of contact by some means yet undetermined with case 2.

Local patients 3, 4, 5 and 6 are all contacts to local case 2; all were vaccinated, showing positive vaccinia at the time of onset and all living at the same address.

Local patient 7, however, deserves especial notice. This is a health department employee in a responsible position in the San Francisco Hospital, allegedly frequently vaccinated but with no evidence of vaccinia; he apparently avoided the general vaccination order of San Francisco Hospital and visited the isolation division of the hospital only in routine duties not connected with any type of case.

Nonlocal patients 8, 9 and 10 are 2 soldiers and 1 sailor en route by ship from Korea and other Oriental ports.

It is of interest that nonlocal patient 10 was released from quarantine, was allowed shore leave and visited numerous places in San Francisco, including crowded theaters; the signs of the rash of smallpox appeared the following day. Two vaccinations were given in a period of three weeks, both classified as nontakes. His original service record indicates an immune reaction but no vaccination scar.

Patient 8, aged 36 years, had an old vaccinia scar of childhood and was supposedly revaccinated in January 1946. Although listed on the record as positive vaccinia, there is no evidence of a recent vaccinial scar.

Patient 9, aged 25 years, showed a vaccination scar supposedly obtained in December 1945; he was revaccinated and does not show a recent vaccinial scar. Furthermore, his record indicates two recent vaccinations, both negative.

Beginning with the first local case, the number of contacts, which were quite numerous including a federal employment agency, were vaccinated; the acceleration of the usual number of vaccinations in schools was begun; all hospitals and clinics were notified and vaccination of staffs was suggested, and notification to physicians was made through the San Francisco County Medical Society Bulletin.

The concentration of local patients 2, 3, 4, 5 and 6 in an overcrowded and substandard housing area made it imperative to begin a vaccination campaign among all citizens by, first, advocating vaccination by the family physician or by hospitals or clinics, both private and public. Therefore the campaign gathered momentum to the extent that, as of April 1, 606,106 vaccine points had been used in San Francisco by all agencies concerned. The campaign is still continuing. The amazing response by an intelligent and health educated community over the years to the appeal for vaccination against smallpox and the estimated 33 per cent positive vaccinia recorded is, it is hoped, a safe sequence to a real threat of a virulent type of smallpox in San Francisco.

J. C. GEIGER, M.D., San Francisco.
Director of Public Health.

SPEAKER'S INDOCTRINATION COURSE

To the Editor:—It is apparent that, with the present aggressive drive for social legislation which is now being carried on, it is necessary for every state and county medical society to have informed public speakers on this subject. The number of physicians who are available for this work is very small and for obvious reasons: either these men are too busy to inform themselves on the subject of socialization of medicine as far as factual information is concerned or they do not have the time required to accept speaking engagements.

For these reasons I should like to suggest that the American Medical Association provide, at some central point such as Chicago or Washington, D. C., a briefing course of three or four days for indoctrination and presentation of factual information as well as any other information which may be useful for speakers who meet the public, particularly the executive secretaries of state and county societies, so that after three or four days of such training these full time men who have been exposed to at least the nucleus of preparation will be in a better position to transmit authentic information to the public. It is taken for granted that the traveling expenses of each of these participants will be paid by the corresponding societies.

We have found that, by sending out speakers on socialized medicine, the public and our cause has benefited greatly. The Allegheny County Medical Society has had speakers appear before various service clubs and community organizations and also has debated this question with proponents of the Wagner-Murray-Dingell legislation.

In fact, these personal contacts have improved our public relations tremendously. Because of the success we have had in Allegheny County with our type of program, we feel that other medical societies might be interested in putting a similar program across.

COMMITTEE ON MEDICAL INFORMATION.
LEO H. CRIEP, M.D., Chairman.
FRED M. JACOB, M.D.
N. C. OCHSENHIRT, M.D.
Pittsburgh.

FILARIASIS

To the Editor:—Since the outbreak of the war in the Pacific and the consequent infection of considerable numbers of American troops with Wuchereria bancrofti, professional persons and laymen have developed a keen interest in filariasis. The search for cure has been followed breathlessly by interested members of both groups. In your editorial of March 16 entitled "Therapy of Filariasis Bancrofti" you point out that considerable progress has been made in the study of antimony compounds in filariasis.

The editorial goes on to say, referring to the work of Culbertson and his associates, "With the exception of 1 patient suffering from periodic chyluria, all were rendered symptom free." To the best of my knowledge it has not been claimed by these workers or by any one else that the antimony compounds are effective in alleviating the symptoms of filariasis.

In some infected human beings it has been possible to observe a decline in the numbers of circulating microfilariae, with final disappearance of these organisms in many cases, following antimony therapy. However, most persons who have circulating microfilariae do not have symptoms of the disease, and, conversely, most of those who have symptoms do not exhibit microfilariae in the blood. With few or no exceptions the members of our armed forces who have been infected belong to the latter group. We do not yet know the effects of antimony compounds in this type of case.

In the original article to which you refer (Culbertson, J. T.; Rose, M. M., and Oliver-Gonzalez, José: *Am. J. Trop. Med.* **25**:403 [Sept.] 1945), under the heading "General Procedures," there is the following statement: "All were free of symptoms of filariasis except one individual, . . . who had periodic chyluria for several years." I feel quite certain that the authors were describing the state of affairs which existed in their patients before the institution of therapy, not the results of therapy.

In view of the fact that a considerable number of persons affected with this disease in symptomatic form have great apprehension about it and are extremely anxious for some form of specific treatment, I believe that it would be of great importance to clarify this matter as soon as possible.

HOWARD B. SHOOKHOFF, M.D., New York.
Epidemiologist, Tropical Diseases.

INFLAMMABLE CLOTHING

To the Editor:—The frequency of serious accidents caused by ignition of highly inflammable clothing has recently brought the problem of hazardous fabrics to public attention, and federal legislation to prohibit the shipment in interstate commerce of hazardous fabrics for clothing has been proposed. In connection therewith the National Bureau of Standards has been asked to compile information on the types of fabrics which have figured in deaths and burns, for use in development of suitable requirements based on applicable tests. The primary interest lies in cases where clothing has burned with unusual rapidity, and particularly where sources of ignition have been small, such as sparks from a fireplace or bonfire, or a struck match.

It is difficult to locate records of such accidents sufficiently complete to provide information on the fabric involved or names and addresses of accident victims who could be contacted directly. The cooperation of physicians and other readers of THE JOURNAL who can supply information thereon will be greatly appreciated.

S. H. INGBERG, Washington 25, D. C.
Chief, Fire Resistance Section, National
Bureau of Standards.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Malpractice: Negligent Roentgen Examination by Chiropractor.—The plaintiff sued the Los Angeles College of Chiropractic and others for damages alleged to have been caused by the malpractice of a chiropractor in examining and x-raying the plaintiff's back. From a judgment against the college and one of the individual chiropractors, the college appealed to the district court of appeal, second district, division 1, California.

The plaintiff injured his back and was taken by a friend to the Los Angeles College of Chiropractic, where defendant Metzinger, a chiropractor, examined him. At the conclusion of the examination, Metzinger told the plaintiff that he had a bad sprain and should have some roentgenograms taken. The plaintiff was then carried to the x-ray laboratory in an adjoining room, where the defendant Joyant, also a chiropractor, who operated the laboratory, made an anterior-posterior x-ray of the plaintiff's pelvis, including the lumbar vertebrae and the lower dorsal vertebrae. After examining the x-ray, Joyant told the plaintiff "Well, this confirms the doctor's diagnosis. There are no bones broken." Plaintiff was then taken home, where he remained in bed for three days suffering intense pain. On the fourth day he called an M.D. and was taken to the Los Angeles General Hospital, where both lateral and anterior-posterior roentgenograms were taken. It was then discovered that the plaintiff was suffering from a compression fracture of the twelfth dorsal vertebra.

The college first contended that Joyant, in operating the x-ray laboratory, was neither its agent nor employee at the time of the plaintiff's examination. The evidence indicated that the ground floor of one of the college buildings was divided into three rooms, with the x-ray laboratory on one side, a chemical laboratory on the other and the college waiting room in between. All the x-ray equipment was owned by the college president, who had owned the laboratory as well for many years. In 1929 an arrangement was made with the defendant Joyant whereby the latter, in return for free rent, telephone and janitor service, agreed to teach the x-ray course in the college whenever it appeared on the curriculum and to perform all necessary x-ray work on the president's patients. Neither the college nor the president, however, prescribed the fees which Joyant could charge his own patients or dictated rules for the operation of the laboratory or the hours during which it should be open. The plaintiff testified that he had never before been treated at the college and knew no one connected with it. After the examination by Metzinger, the plaintiff was taken into the x-ray room, where Joyant made the roentgen examination, following which Joyant said that his regular charge was $15 but that because the plaintiff's friend was a former student at the college he would charge only $7.50.

Before a recovery can be had against a principal for the alleged act of an ostensible agent, said the court, it must be shown that the third person dealing with the agent did so with a reasonable belief in the agent's authority, that the belief was generated by some act or neglect of the principal sought to be charged and that the third person, in relying on the agent's apparent authority, was not guilty of any negligence on his own behalf. So far as the record reveals, the court said, the college did nothing to put the plaintiff on notice that the x-ray laboratory was not an integral part of the institution, and it cannot seriously be contended that the plaintiff, when he was being carried from room to room suffering excruciating pain, should have inquired whether the individual doctors who examined him were employees of the college or were independent contractors. Agency is always a question of fact for the jury, and the court held that the evidence in the case was sufficient to support the jury's implied finding that Joyant was the ostensible agent of the college.

The college also contended that there could be no recovery against an x-ray technician unless two facts are established: negligence on the part of the technician, and evidence that the

pictures were used by physicians in treating the plaintiff or as a diagnostic aid. The record reveals, said the court, that Joyant did not follow the generally accepted practice of taking a lateral, as well as an anterior-posterior, x-ray wherever an injury to the spine is indicated. Furthermore, he developed and read the roentgenograms immediately after he took them and made the positive statement "Well, this confirms the doctor's diagnosis. There are no bones broken." It must therefore be assumed that the pictures were taken as a diagnostic aid and that if Joyant had discovered that the plaintiff's back was broken he would have made known that fact so that further attention could have been given to the injury. The court concluded therefore that the evidence produced at the trial amply supported the jury's verdict that Joyant was negligent and that such negligence was the proximate cause of damages to the plaintiff. Accordingly the judgment in favor of the plaintiff was affirmed.—*Stanhope v. Los Angeles College of Chiropractic, 128 P. (2d) 705 (Calif., 1942).*

Evidence: Results of Blood Grouping Tests Held Admissible in Rape Case.—From a conviction for rape the defendant appealed to the Court of Appeals of Maryland.

The evidence showed that the prosecuting witness, about 2 o'clock one morning, was seized by some one, beaten, carried into a vacant yard, kept there for some time, criminally assaulted twice and then permitted to leave. The defendant was arrested the following morning, police having discovered that he had been in the neighborhood of the crime. At the time of his arrest, a blood stained overcoat was found in his room. He said these blood stains were the result of a fight he had had with a colored girl named Elizabeth Moore. She was questioned by the police in the defendant's presence and admitted that she had been in a fight with him, as the result of which defendant had given her a bloody nose. Defendant did not say whether the blood on his coat came from the scratches on his own face or from the nose of the colored girl. Defendant was identified by the prosecuting witness as the man who had assaulted her. A motorman on a street car said he, the morning of the assault, noticed that the defendant's face was scratched and that he had blood on his overcoat. The clothes of the prosecuting witness had blood on them which she testified had not been there before the attack, and a doctor who examined her on the morning of the attack testified that she was bleeding at that time. A police sergeant found blood on the snow in the yard in which the offense had been committed and also saw the prosecuting witness with blood running into her eyes. The bloody coat of the accused was offered in evidence.

During the course of the trial, evidence was offered of the results of various blood tests, taken by Dr. Freimuth, a toxicologist attached to the office of the chief medical examiner of the state and former toxicologist and serologist of the Federal Bureau of Investigation in Washington. No objection was made to the qualification of Dr. Freimuth, but the admission in evidence of the result of these tests was objected to and constitutes the basis for this appeal.

Scientific tests of human blood, said the court, are now almost universally used in appropriate cases and the results are accepted as evidence where they are found to be admissible for the purpose offered in a particular legal proceeding. The possibilities were first brought to the attention of the medical world when Dr. Karl Landsteiner, afterward a Nobel prize winner, announced in 1900 the result of his experiments showing that all persons, without regard to race, sex or health, could be divided into three blood groups (later increased to four). Other discoveries were made later, and the blood tests now given are generally known as the Landsteiner-Wiener, Landsteiner-Levine or Landsteiner-Bernstein tests. These tests have been recognized by the courts in Europe since 1924, their chief use being in paternity cases. In Germany they had been used in over 5,000 cases by 1929, and in Great Britain they were used in two murder cases as early as 1930 and 1931. The first case in this country seems to have been in 1931. In the early cases evidence of the tests was not admitted, because the courts here were not convinced of their general acceptance and reliability. Blood tests are now accepted everywhere as scientifically accurate, and the courts and legislatures have generally followed the same view. Trial courts in this state have so accepted them for a number of years. Dr. Freimuth testified that there are in the main four major blood groups in the international system of grouping. They are group O, in which you will find approximately 45 per cent of the population; group A, in which you will find approximately 42 per cent of the population; group B, in which you will find approximately 10 per cent of the population, and group AB, in which you will find the remaining 3 per cent. For the purpose of testifying in this case Dr. Freimuth made five separate blood tests, which showed as follows:

Blood from coat of accused, type O.

Blood from Elizabeth Moore, the colored girl with whom the accused had a fight, type A.

Blood from the prosecuting witness, type O.

Blood from clothes of prosecuting witness, type O.

Blood from the snow found in the yard, type O.

The defendant argued that the testimony of Dr. Freimuth with respect to the blood found on the coat of the defendant should have been excluded because it violated the constitutional right of a defendant to refuse to testify against himself. It is difficult to say how this contention can be sustained, said the court. Clothing is admissible in evidence if it is so connected with a crime as to throw light on a material inquiry in the case. The defendant attempted to rely on a case in which the court had refused to require the accused to try on a hat found at the scene of the crime. The court said there is a distinction between experiments made by the accused in court and experiments made outside of court and testified to by other witnesses.

> The difference is this, . . . that when such comparisons and experiments are made outside of court, the evidence thereto falls from the lips of witnesses other than the defendant. The production of such evidence, therefore, and the testimony thereto, is not that of the defendant but of other witnesses; while, on the other hand, if the defendant is required against his objection in open court, in the presence of the jury, to make such experiments and comparisons, no extraneous evidence is required, and the constitutional prohibition is thereby violated.

In the case at bar the defendant did not testify. The blood was taken from his coat, and the evidence as to it was produced by another witness. We can find no justification for his contention that his constitutional rights were violated in this respect.

The judgment and sentence of the defendant was therefore affirmed.—*Shanks v. State, 45 A. (2d) 85 (Md., 1945).*

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

BOARDS OF MEDICAL EXAMINERS
BOARDS OF EXAMINERS IN THE BASIC SCIENCES

Examinations of the boards of medical examiners and boards of examiners in the basic sciences were published in THE JOURNAL, March 20, page 1189.

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: Parts I and II. Various Centers, May 6-8. Exec. Sec., Mr. E. S. Elwood, 225 S. Fifteenth St., Philadelphia 2.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY: *Oral.* New York, Oct. 9-14. Sec., Dr. Paul M. Wood, 745 Fifth Ave., New York 22.

AMERICAN BOARD OF INTERNAL MEDICINE: *Written.* Oct. 21. Final date for filing application is July 1. Asst. Sec., Dr. W. A. Werrell, 1 W. Main St., Madison 3, Wis.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: *Oral.* Chicago, May 6-11. Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh.

AMERICAN BOARD OF OPHTHALMOLOGY: *Oral. All Groups. Parts I and II.* New York, June 1947. Final date for filing application is Dec. 1. Chicago, October 1947. Final date for filing application is March 1. Sec., Dr. S. J. Beach, 56 Ivie Rd., Cape Cottage, Me.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: *Part II. Oral.* Chicago, January. Final date for filing application is Nov. 1. Sec., Dr. Guy A. Caldwell, 1136 W. Sixth St., Los Angeles 14.

AMERICAN BOARD OF OTOLARYNGOLOGY: Chicago, May 22-25. Sec., Dr. Dean M. Lierle, University Hospital, Iowa City, Ia.

AMERICAN BOARD OF PATHOLOGY: San Francisco, June 25-26. Applications should be submitted by May 15. Sec., Dr. F. W. Hartman, Henry Ford Hospital, Detroit 2.

AMERICAN BOARD OF PEDIATRICS: *Oral.* Cleveland, April 27-28 and San Francisco, July 1-5. Sec., Dr. Lee F. Hill, 3309 Forest Ave., Des Moines, Ia.

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY: New York, December. Final date for filing application is Sept. 30. Sec., Dr. Walter Freeman, 1028 Connecticut Ave. N.W., Washington, D. C.

AMERICAN BOARD OF RADIOLOGY: Chicago, Nov. 27 to Dec. 1. Final date for filing application is Sept. 1. Sec., Dr. B. R. Kirklin, Mayo Clinic, Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Written. Part I.* Various centers, October. Final date for filing application is July 1. Sec., Dr. J. S. Rodman, 225 S. 15th St., Philadelphia 2.

AMERICAN BOARD OF UROLOGY: *Oral.* Chicago, February 1947. Final date for filing application is Nov. 15. Sec., Dr. Gilbert J. Thomas, 1409 Willow St., Minneapolis 4.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1936 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied with stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

Alabama State Medical Assn. Journal, Montgomery

15:201-228 (Jan.) 1946

Surgical Treatment of Inguinal Hernia. W. C. Simpson.—p. 201.
Evaluation of Various Case Finding Procedures in Tuberculosis Control Program. W. Grosfeld.—p. 204.
Further Data on Pathogenesis of Fibroblastic Neoplasms: Density Ratio of Tissue Computed by Author's Exposure Meter Method. W. Marshall.—p. 206.
Lipoid Nephrosis: Review of Disease, with Report of Case. E. A. Harris and M. G. Neely.—p. 208.

15:229-252 (Feb.) 1946

Consideration of Patient and His Disease: Five Case Reports. E. Dice Lineberry.—p. 229.
Intravenous Fluids. F. H. Craddock Jr.—p. 234.
Thiouracil. E. Drennen.—p. 236.
Clinical Use of Diuretics. R. O. Russell.—p. 237.

American Journal of Medical Sciences, Philadelphia

211:1-128 (Jan.) 1946

*Prefrontal Lobotomy: Survey of 331 Cases. W. Freeman and J. W. Watts.—p. 1.
Scrub Typhus Fever (Tsutsugamushi Disease) in New Guinea: Report of 75 Cases. T. H. Mendell.—p. 9.
Clinical Significance of Cold Hemagglutinins. L. E. Young.—p. 23.
Clinical Arrest in Enterococcal Endocarditis. W. J. MacNeal, Anne Blevins and C. A. Poindexter.—p. 40.
Use of "Modified Globin" from Human Erythrocytes in Hypoproteinemias. M. M. Strumia, A. D. Blake, H. C. Reider and F. W. Chornock.—p. 51.
Fatal Agranulocytosis, with Autopsy Following Use of Thiouracil in Case of Thyrotoxicosis. A. Trasoff, M. G. Wohl and S. S. Mintz.—p. 62.
Therapeutic Value of Early Physical Activity in Rheumatic Fever: Preliminary Report. H. F. Robertson, R. E. Schmidt and W. Feiring.—p. 67.
Relationship of Blood Pressure and Serum Thiocyanate. W. F. Connell, G. K. Wharton and C. E. Robinson.—p. 74.
Palmar Erythema—Its Relationship to Protein Deficiency. R. M. Johnson and H. H. Hecht.—p. 79.
Simplified Apparatus for Induction of Artificial Pneumoperitoneum. B. O. Lewis.—p. 84.
Occurrence of Fibrinolysis in Shock, with Observations on Prothrombin Time and Plasma Fibrinogen During Hemorrhagic Shock. H. J. Tagnon, S. M. Levenson, C. S. Davidson and F. H. L. Taylor.—p. 88.
Observations on Specificity and Clinical Use of Dirofilaria Immitis Antigen in Diagnosis of Human Filariasis (Wuchereria Bancrofti). M. Zarrow and H. Rifkin.—p. 97.
Treatment of Bacillary Dysentery in Chinese Soldiers with Sulfaguanidine and Sulfadiazine. K. A. Elsom, D. S. Pepper and J. S. Forrester.—p. 103.
Infectious Polyneuritis (Guillain-Barré Syndrome). R. L. Pullen and W. A. Sodeman.—p. 110.

Prefrontal Lobotomy.—Freeman and Watts performed prefrontal lobotomy in 331 cases during the last nine years. This surgical procedure is to be employed only in cases in which a favorable outcome is not to be anticipated under more conservative measures. It should not be postponed too long, however, since deterioration may progress to the point where operation will no longer be serviceable. The most favorable results are obtained in obsessive tension states, with or without compulsions, in hypochondriasis and intractable psychosomatic conditions and in agitated depressions. Less satisfactory results are obtained in schizophrenias, although as long as the patient is fighting his disease there still remains the possibility of satisfactory modification of his disturbed behavior. Alcoholism, paranoid states and psychoses with organic brain diseases yield rather poor results. The treatment of structurally conditioned painful disorders is giving favorable results. The most important sequels are inertia, aggressiveness and epileptic seizures, but these are disabling in only a minor percentage of cases. About half the patients are usefully occupied, one fourth remain at home and one fourth are dead or institutionalized.

American Journal of Physiology, Baltimore

145:273-446 (Jan.) 1946. **Partial Index**

Thrombopenia of Anaphylactic and Peptone Shock. A. J. Quick, R. K. Ota and I. D. Baronofsky.—p. 273.
*Role of Exercise in Altitude Pain. F. M. Henry.—p. 279.
Elimination of Administered Cobalt in Pancreatic Juice and Bile of Dog, as Measured with Its Radioactive Isotopes. G. E. Sheline, I. L. Chaikoff and M. L. Montgomery.—p. 285.
Visual Thresholds as Index of Physiologic Imbalance During Insulin Hypoglycemia. R. A. McFarland, M. H. Halperin and J. I. Niven.—p. 299.
Effects of Acute Hemorrhagic and Traumatic Shock on Renal Function of Dogs. R. A. Phillips, V. P. Dole, P. B. Hamilton and others, with technical assistance of Emily G. Stanley and W. H. Becker.—p. 314.
Renal Extraction of Oxygen in Experimental Shock. V. P. Dole, K. Emerson Jr., R. A. Phillips, P. Hamilton and D. D. Van Slyke.—p. 337.
Effect of Oxygen Pressure on Uptake of Carbon Monoxide by Man at Sea Level and at Altitude. J. L. Lilienthal Jr. and Mary B. Pine.—p. 346.
Relationships Between Carbon Monoxide, Oxygen and Hemoglobin in Blood of Man at Altitude. J. L. Lilienthal Jr., R. L. Riley, D. D. Proemmel and R. E. Franke.—p. 351.
Effect of Low Concentrations of Carboxyhemoglobin on "Altitude Tolerance" of Man. J. L. Lilienthal Jr. and C. H. Fugitt.—p. 359.
Blood Sugar Levels and Carbohydrate Administration in Human Subjects During Prolonged Exposures to Moderately Low Altitudes. S. A. D'Angelo.—p. 365.
Comparison of Renal Clearances with Direct Renal Blood Flow Under Control Conditions and Following Renal Ischemia. E. E. Selkurt.—p. 376.
Further Observations on Induced Ovulation in Mouse as Rapid Test for Pregnancy. H. O. Burdick.—p. 387.
Energy Cost of Horizontal and Grade Walking on Motor Driven Treadmill. L. Erickson, E. Simonson, H. L. Taylor, H. Alexander and A. Keys.—p. 391.
*Effect of Low and High Carbohydrate Meals on Blood Sugar Level and on Work Performance in Strenuous Exercise of Short Duration. J. Haldi and W. Wynn.—p. 402.
Effect of Diethylstilbestrol on Thyroidectomized Rats. R. G. Janes.—p. 411.
Effect of Compounds Related to Glycolysis in Muscle on Sensitivity of Muscle to Acetylcholine and Potassium. Clara Torda and H. G. Wolff.—p. 419.
Arterial Oxyhemoglobin Saturations at Critical Pressure Altitudes Breathing Various Mixtures of Oxygen and Nitrogen, with Note on Effect of Exercise. J. L. Lilienthal Jr., R. L. Riley and D. D. Proemmel.—p. 427.

Exercise in Altitude Pain.—Henry exposed healthy young men to a reduced barometric pressure of 155 mm., equivalent to an altitude of 38,000 feet, in a decompression chamber. Pure oxygen was supplied so that alveolar oxygen was maintained at normal ground level tension. While at the simulated altitude for ninety minutes, unless forced to return to ground level pressure sooner because of incapacitating symptoms, the men performed one or another of six arm exercises designed to separate out factors such as continuous and intermittent strain, total work and angular joint movement. The presence and severity of pain (aviator's "bends") or other symptoms was recorded at intervals of two and a half minutes. Pain occurred in unexercised limbs but was much more common and more severe in exercised limbs. Onset time, incidence and severity of pain were systematically related to total work (in foot pounds). There is an indication that the occurrence of mild pain is differentially affected by small amounts of work but not further increased at the highest work level studied. Muscle strain, mechanical tension and amount of joint movement did not determine the occurrence or severity of pain. This is true for both continuous and intermittent tension. These results support a theory that increased local carbon dioxide production is principally responsible for the effects of exercise on the occurrence and severity of altitude pain.

Effect of Meals on Blood Sugar and Work Performance.—Haldi and Wynn made blood sugar determinations on finger tip blood of 59 normal healthy young adults two and a half to three hours after a low and a high carbohydrate breakfast containing approximately 400 calories. There was no appreciable difference in the blood sugar level after the two types of meals. Blood samples were obtained by the same procedure on 50 subjects one, two and three hours after a low and a high carbohydrate breakfast containing approximately 600

calories (50 per cent more calories than the breakfast ingested in the preceding experiments). On 38 additional subjects venous and finger tip blood was drawn simultaneously. The average blood sugar (arterial and venous) was within the normal range. In a few instances the sugar concentration of venous blood fell below 70 mg. per hundred cubic centimeters, but these low values, which are regarded as normal deviations, occurred in about equal frequency after the low and the high carbohydrate meals. There was no relationship between the blood sugar level and the sense of hunger and weakness. The performance of swimmers in a hundred yard sprint was the same two and a half to three hours after a high carbohydrate meal and an isocaloric meal containing a low percentage of carbohydrate. There was no difference in the blood sugar level two and a half to three hours after these low and high carbohydrate meals. Immediately after swimming, the blood sugar concentration was higher than before swimming but was the same on the two types of meals. A high carbohydrate meal is not conducive to hypoglycemia and its usual symptoms of hunger, weakness and fatigue several hours later in normal, healthy persons. It is concluded that the hypoglycemia syndrome that is relieved by restriction of the carbohydrate intake is a pathologic condition and not a normal physiologic response to a high carbohydrate meal.

Archives of Internal Medicine, Chicago

76:257-404 (Nov.-Dec.) 1945

*Acute Myocarditis in Mumps (Epidemic Parotitis). D. H. Rosenberg.—p. 257.
Pneumothorax in Young Adult Males: Descriptive Statistics in 126 Cases. J. E. Leach.—p. 264.
Streptomycin for Certain Systemic Infections and Its Effect on Urinary and Fecal Flora. H. A. Reimann, A. H. Price and W. F. Elias.—p. 269.
Hemolytic Streptococcus Sore Throat: Detailed Study of Simultaneous Infection of Large Number of Men by Single Type. L. A. Rantz, W. W. Spink and P. J. Boisvert.—p. 278.
Small Adenomas of Adrenal Cortex in Hypertension and Diabetes. S. Russi, H. T. Blumenthal and S. H. Gray.—p. 284.
Paroxysmal Hemoglobinuria Due to Cold Hemolysin: Observations with Report of Case of Its Occurrence in Aerial Gunner. E. D. Maire.—p. 292.
Congenital Idiopathic Methemoglobinemia: Favorable Response to Ascorbic Acid Therapy. R. F. Sievers and J. B. Ryon.—p. 299.
Study of Water and Heat Loss from Respiratory Tract of Man: Methods: I. Gravimetric Method for Measurement of Rate of Water Loss; II. Quantitative Method for Measurement of Rate of Heat Loss. G. E. Burch.—p. 308.
Rate of Water and Heat Loss from Respiratory Tract of Normal Subjects in Subtropical Climate. G. E. Burch.—p. 315.
Observations on Primary Atypical Pneumonia. J. Grossman.—p. 328.
Acute Porphyria: Clinical and Pathologic Observations. M. Berg.—p. 335.
Relation of Nutritional Deficiency to Cardiac Dysfunction. M. M. Wintrobe.—p. 341.
*Extragenital Chorionepithelioma in Male. H. M. Chernoff, T. S. Evans and C. J. Bartlett.—p. 347.
Plasma Quinacrine Concentration in Treatment of Plasmodium Vivax Malaria Acquired in South Pacific. L. D. Ellerbrook, S. W. Lippincott, C. F. Cateno, H. H. Gordon and A. Marble.—p. 352.
Blood: Review of Recent Literature. F. H. Bethell, C. C. Sturgis, R. W. Rundles and Muriel C. Meyers.—p. 358.

Acute Myocarditis in Mumps.—Rosenberg observed a complete heart block in a sailor, aged 20, who was convalescing from epidemic parotitis. Diagnosis of acute myocarditis was made from the electrocardiographic changes, and, in the absence of any other etiologic agent, the condition was ascribed to the virus of mumps. Another patient was observed who during the course of mumps manifested electrocardiographic evidence of partial heart block which progressed to complete heart block and ultimately returned to normal. In 104 consecutive cases of mumps in adults, electrocardiographic evidence of myocardial involvement was found in 16 instances (15.4 per cent). Mumps myocarditis appears as a rule between the fifth and tenth days of illness and is usually mild and transitory. In the majority of instances it follows a subclinical course and is recognizable chiefly, if not exclusively, by electrocardiographic studies. Precordial pain, dyspnea and/or palpitation appeared in 4 cases of this series and in the 2 reported in this paper. The author suggests that perhaps too much emphasis is attached to the delayed conduction time in the differential diagnosis of rheumatic fever. Other acute infections that are prevalent in epidemic form when the incidence of rheumatic fever is at its peak, such as pneumonia, diphtheria and German measles, were also found with electrocardiographic abnormalities, including a prolonged PR interval. The author also suggests that epidemic parotitis is a generalized infection and that any acute infectious disease, bacterial or viral in origin, is capable of affecting the heart.

Extragenital Chorionepithelioma in the Male.—Chernoff and his associates report the history of a man, aged 30, who had gynecomastia, pain in the lumbar region, hemoptysis, loss of weight and a rapid downhill course. The production by the tumor of large amounts of gonadotropic hormone was demonstrated by the highly positive reaction to the Friedman test with both urine and spinal fluid. The enlargement of the breasts, the absence of spermatogenesis and the interstitial hyperplasia noted in the testis are considered to have been produced by the excessive amounts of this hormone. Intensive roentgen therapy over a period of five months did not alter the outcome, although it did produce some symptomatic relief and some decrease in the size of the pulmonary metastases.

Archives of Pathology, Chicago

41:1-120 (Jan.) 1946

Absorption of Scar Tissue in Experimental Nodular Cirrhosis of Liver, with Method of Visualizing Cirrhotic Changes. B. Steinberg and Ruth A. Martin.—p. 1.
Microscopic Lesions in Acetylcholine Shock. R. Altschul and M. M. Laskin.—p. 11.
*Relation of Cholelithiasis to Acute Hemorrhagic Pancreatitis. D. W. Molander and E. T. Bell.—p. 17.
Experimental Pituitary Diabetes of Five Years' Duration with Glomerulosclerosis. F. D. W. Lukens and F. C. Dohan.—p. 19.
Morphologic Studies of Rats Deprived of Essential Amino Acids: III. Histidine. M. E. Maun, W. M. Cahill and Ruth M. Davis.—p. 25.
Occurrence of Rheumatic Carditis in Native Population of Curaçao, Netherlands West Indies. P. H. Hartz and Ary van der Sar.—p. 32.
Fat Necrosis Studies: VI. Effect of Feeding Lipase-Containing Vegetable Seed on Production of Fat Necrosis. M. P. Neal.—p. 37.
Experimental Nephropathies: IV. Glycosuria in Dogs Poisoned with Uranyl Nitrate, Mercury Bichloride and Potassium Dichromate. O. E. Hepler and J. P. Simonds.—p. 42.
Leukopenia and Inflammation: Presence of Leukopenic Factor in Inflammatory Exudates. V. Menkin.—p. 50.
Tropical Diseases: Involvement of Nervous System. W. S. Chalgren and A. B. Baker.—p. 66.

Cholelithiasis and Acute Hemorrhagic Pancreatitis.—According to Molander and Bell, necropsy records of the department of pathology of the University of Minnesota show acute hemorrhagic pancreatitis encountered in 158 of 41,333 persons examined post mortem. The frequency of cholelithiasis associated with acute pancreatitis in the necropsy series is shown along with Ludlow's report of the occurrence of cholelithiasis in 4,800 persons examined post mortem. Cholelithiasis is observed much oftener in necropsies on persons with acute pancreatitis than in necropsies on people in general. In about two thirds of the males and one third of the females with acute pancreatitis this disease develops in the absence of gallstones, but since gallstones are found about six times as frequently in both males and females with acute pancreatitis as in the necropsy population in general there must be some causal relation between the two findings.

Bulletin of Los Angeles Neurological Society

10:85-180 (Sept.-Dec.) 1945

*Chronic Pain as Residual of Poliomyelitis of Southern California. J. M. Nielsen.—p. 85.
Iron Encrustation of Nerve Cells in Vicinity of Old Traumatic Lesions of Cerebral Cortex. C. W. Rand and C. B. Courville.—p. 95.
Successful Treatment of Posttraumatic Pneumococcic Meningitis with Large Doses of Penicillin. K. H. Abbott and P. J. Vogel.—p. 107.
Intracranial Complications of Infections of Nasal Air Passages and Accessory Sinuses: Further Report on Nature and Incidence of Lesions Observed in Series of 30,000 Autopsies. W. W. H. Pote Jr. and C. B. Courville.—p. 114.
Notes on Pathology of Cranial Tumors: II. Metastatic Tumors of Calvarium with Incidental Reference to Their Occurrence in American Aborigines. C. B. Courville and K. H. Abbott.—p. 129.
Ancestry of Neuropathology: Robert Hooper's "Morbid Anatomy of Human Brain." C. B. Courville.—p. 155.
Palmomental Sign. G. N. Thompson.—p. 174.
Desire to Sing as Aura of Epilepsy: Case Report. H. Tompkins.—p. 176.

Chronic Pain as Residual of Poliomyelitis.—Nielsen observed a new syndrome of chronic pain as a residual of polyneuritic poliomyelitis in 15 cases in southern California. Reports of 6 are presented. The condition is characterized by neuritic and radicular pains, acroparesthesias and a myotonic syndrome-like myotonia congenita. After a subacute onset of

pains the course becomes chronic and continues for years with exacerbations and remissions, possibly with a slow downward course. The sharp, shooting pains are almost exactly like those of tabes dorsalis. They affect not only the extremities but also the roots of the trunk and those supplying the trigeminal area. The pains differ from those of tabes in that they do not leave areas of hyperesthesia unless they become almost constant and then late in the disease. Then large areas are extremely sensitive to light touch but not to heavy pressure. All symptoms of destruction are extremely rare; the syndrome is almost exclusively irritative. The distribution of the gripping pains is that of the peripheral nerves. The acroparesthesias, the typical numbness of the hands and feet, are exactly like those of any sensory polyneuritis. The muscle spasms and myotonic syndrome seem related not to any circulatory deficiency but rather to the muscles themselves or to their nervous supply. But the anomalous condition exists that there is no tenderness of the nerve trunks or of the muscles in which the supposedly affected nerve endings are located, unless the muscles are forced to contract many times by voluntary use. After such exercise there is much spontaneous pain in the group and a burning pain referred to the overlying skin. So far as known, the syndrome does not respond to any treatment.

Journal of Bacteriology, Baltimore

50:613-728 (Dec.) 1945. **Partial Index**

Influence of Streptomycin and Streptothricin on Intestinal Flora of Mice. Dorothy G. Smith and H. J. Robinson.—p. 613.
Broth Dilution Method of Assaying Streptothricin and Streptomycin. R. Donovick, Dorothy Hamre, F. Kavanagh and G. Rake.—p. 623.
Dehydrogenase Characteristics of Pneumococci. L. L. Bambas.—p. 629.
*In Vitro and In Vivo Activity of Streptomycin Against Hemophilus Pertussis. C. P. Hegarty, Elizabeth Thiele and W. F. Verwey.—p. 651.
Diphtherial Toxoid Purified by Absorption. I. A. Parfentjev and M. A. Goodline.—p. 661.
Isolation of Four Salmonella Types from One Carrier. A. P. Juenker. —p. 673.
Structure of Spirocheta Novyi as Revealed by Electron Microscope. Ruth Lofgren and M. H. Soule.—p. 679.
Decomposition of Tartrates by Some Common Fungi. Thressa C. Stadtman, R. H. Vaughn and G. L. Marsh.—p. 691.
Assay of Streptomycin by Paper Disk Plate Method. Y. H. Loo, P. S. Skell and H. H. Thornberry, J. Ehrlich and others.—p. 701.
Sources of Amylase-Producing Bacteria. G. L. Peltier and L. D. Beckord.—p. 711.

Streptomycin Against Hemophilus Pertussis.—Hegarty and his associates found that streptomycin exhibited in vitro bacteriostatic activity against Hemophilus pertussis at a concentration of 3 micrograms per cubic centimeter and was bactericidal at 15 micrograms per cubic centimeter. Infection of mice with 40,000 organisms and treatment with 0.5 mg. of streptomycin per day for five days resulted in an average survival time approximately twice that of the controls but an ultimate mortality of 90 per cent of the animals. Infection with 5,000 organisms and daily treatment with 2 mg. of streptomycin for ten days protected 50 per cent of the mice. The mean survival time for those that died was twenty-two days as compared with 5.5 days for the controls. Further investigations of the use of streptomycin in the therapy of H. pertussis infection are suggested.

Journal of Clin. Endocrinology, Springfield, Ill.

5:407-456 (Dec.) 1945

*Further Observations on Value of Pregnandiol Test for Pregnancy. H. S. Guterman.—p. 407.
Testosterone Propionate in Treatment of Senile Pruritus. W. L. Dobes, J. Jones and A. G. Franks.—p. 412.
Reliability of Aschheim-Zondek Test in Pregnancy: Report of Two Thousand Routine Tests. J. Engelfried, Gladys E. Hawkinson and Vera F. Galandey.—p. 419.
Thiouracil Derivatives of Greater Activity for Treatment of Hyperthyroidism. E. B. Astwood and W. P. VanderLaan.—p. 424.

Pregnandiol Test for Pregnancy.—Guterman reports the results of the pregnandiol color reaction test for pregnancy in 248 obstetric cases with an accuracy of 92 per cent. The accepted Friedman test was recorded as 87 per cent correct in this same series. The standard for a "positive" reaction has been altered to a deep yellow which avoids "false negative" results and does not increase the incidence of "false positives." The infrequency of the occurrence of proved corpus luteum cysts is indicated. It does not therefore affect the accuracy of this pregnancy test. Patients with hydatid moles and chorionic neoplasms do not excrete sufficient pregnandiol to give a "positive" reaction. Since six tests can be performed simultaneously in three hours, the time devoted to each test is half an hour. This is less time than has been found necessary to devote to an individual Friedman test.

Journal of Neurophysiology, Springfield, Ill.

9:1-60 (Jan.) 1946

Reflex Pupillodilator Mechanisms: An Experimental Analysis. A. Kuntz and C. A. Richnins.—p. 1.
Effects of Inhibitors of Choline Esterase on Nerve Action Potential. T. H. Bullock, D. Nachmansohn and M. A. Rothenberg.—p. 9.
Mechanism of Electrophonic Effect. P. Kellaway.—p. 23.
Rapid Changes in Cerebral Oxygen Tension Induced by Altering Oxygenation and Circulation of Blood. E. Roseman, C. W. Goodwin and W. S. McCulloch.—p. 33.
Carbonic Anhydrase in Nervous System. H. W. Davenport.—p. 41.
Effect of Cellular Hydration on Experimental Electroshock Convulsions. E. A. Swinyard, J. E. P. Toman and L. S. Goodman.—p. 47.
Recovery of Motor Function After Two-Stage Extirpation of Area 4 in Monkeys (Macaca Mulatta). H. W. Ades and D. H. Raab.—p. 55.

Journal of Nutrition, Philadelphia

31:1-140 (Jan.) 1946

Determination of Metabolic Fecal Nitrogen and Protein Digestibility. D. K. Bosshardt and R. H. Barnes.—p. 13.
Use of Mice for Measurement of Growth Promoting Quality of Proteins. D. K. Bosshardt, Laura C. Ydse, Mary M. Ayres and R. H. Barnes. —p. 23.
Energy and Gaseous Metabolism of Chicken from Hatch to Maturity as Affected by Temperature. H. G. Barott and Emma M. Pringle. —p. 35.
Thiamine, Riboflavin, Nicotinic Acid and Pantothenic Acid Content of Colostrum and Milk of Cow and Ewe. P. B. Pearson and A. L. Darnell.—p. 51.
Vegetable Crops in Relation to Soil Fertility: IV. Nutritional Values of New Zealand Spinach. S. H. Wittwer.—p. 59.
Relation of Vitamin A Intake to Length of Life, Growth, Tooth Structure and Eye Condition. H. E. Paul and Mary F. Paul.—p. 67.
Nicotinic Acid Deficiency in Turkey Poults and Occurrence of Perosis. G. M. Briggs.—p. 79.
Factors Affecting Dietary Niacin and Tryptophan Requirement of Growing Rat. W. A. Krehl, P. S. Sarma, L. J. Teply and C. A. Elvehjem.—p. 85.
Relation of Amount of Thiamine in Ration of Hog to Thiamine and Riboflavin Content of Tissue. W. W. Heinemann, M. E. Ensminger, T. J. Cunha and E. C. McCulloch.—p. 107.
Further Studies on Calcium Requirement of Preschool Children. Dorothy Sheldon McLean, Gladys Kinsman Lewis, Elizabeth Jensen and others. —p. 127.

Journal of Urology, Baltimore

55:1-42 (Jan.) 1946. **Partial Index**

Report of Case of Acute Hemorrhagic Adrenalitis. V. J. Oddo.—p. 1.
*Relief of Renal Colic and Renal Suppression: Preliminary Report. I. R. Trimble and M. C. Sanford.—p. 4.
Pyelographic Sign in Diagnosis of Perinephric Abscess. D. T. Prehn. —p. 8.
Renal Adenomas in Hypernephromatous Kidneys: Study of Their Incidence, Nature and Relationship. D. S. Cristol, J. R. McDonald and J. L. Emmett.—p. 18.
Liposarcoma of Kidney: Report of Case Presenting Unusual Syndrome. G. W. Fish and W. L. McLaughlin.—p. 28.
Mucinous Adenocarcinoma of Pelvis of Kidney. L. V. Ackerman.—p. 36.
Ureteropelvic Obstructions in Children: Incidence and Etiology. P. J. Soley.—p. 46.
Circumcaval Ureter: Report of Case, with Consideration of Preoperative Diagnosis and Successful Plastic Repair. L. F. Greene and W. M. Kearns.—p. 52.
Unusual Ureteral Anomalies: Case Reports. E. F. Nation.—p. 60.
Congenital Diverticulum of Female Urethra. S. McMahon.—p. 69.
Study of Effect of Stilbestrol Therapy on Size of Benignly Hypertrophied Prostate Gland. E. L. Peirson.—p. 73.
Importance of Routine Cystoscopy in Prostatism. J. A. Lazarus.—p. 79.
Osteitis Pubis. H. H. Cohen.—p. 84.
Urogenital Complications of Dengue Fever. H. M. Weyrauch and H. Gass.—p. 90.
War Injuries of Urinary Tract. G. C. Prather.—p. 94.
Urogenital Wounds in Evacuation Hospital. D. F. Marshall—p. 119.
Penicillin in Propylene Glycol: Preliminary Report. F. L. Senger, H. L. Warren and I. Rifkin.—p. 138.

Relief of Renal Colic and Renal Suppression.—Trimble and Sanford report a case in which bilateral renal colic and anuria developed during sulfadiazine therapy. The colic was relieved within ten minutes after procaine hydrochloride injection of the lumbar sympathetic nerve trunk; the anuria of forty-eight hours' duration was terminated two hours following the first injection. In a second patient with renal colic due to a ureteral stone the same procedure was followed by temporary

relief of pain and by the passage of the stone. The authors believe that renal colic can be completely, even though temporarily, relieved by sympathetic trunk injection and that a sympathetic trunk block is indicated in certain types of anuria.

Tennessee State Medical Assn. Journal, Nashville

39:1-36 (Jan.) 1946

Common Macrocytic Anemias. H. C. Long.—p. 1.
Toxic Psychosis Due to Bromides. F. F. Dupree.—p. 4.
Problem of Hypertension. A. Weinstein.—p. 8.
Rabies. T. L. Chiffelle.—p. 14.

39:37-76 (Feb.) 1946

Report of House of Delegates of American Medical Association. E. G. Wood.—p. 37.
The Doctor and His Medical Society. H. Acuff.—p. 41.
Diagnosis and Treatment of Common Anorectal Diseases. O. C. Gass.—p. 45.
Errors Commonly Encountered in Cardiac Diagnosis in Military Personnel. T. F. Frist.—p. 51.

War Medicine, Chicago

8:283-448 (Nov.-Dec.) 1945

Public Health in France from Invasion to Liberation. L. J. Besançon.—p. 283.
War Injuries of Eyes and Visual Pathways. G. C. Struble and A. J. Kreft.—p. 290.
*Quinacrine Hydrochloride as Malaria-Suppressive Agent for Combat Troops. G. G. Duncan.—p. 305.
Experiences with Amebiasis in Evacuation Hospital. A. G. Brown.—p. 319.
Nutritional Disease in Cabanatuan. M. M. Musselman.—p. 325.
*Problem of Hemolytic Streptococcus Carriers in Hospital Personnel. F. F. Harrison and J. K. Miller.—p. 333.
Psychiatric Program for Naval Receiving Station. J. B. Dynes, N. Norton Springer and F. H. Thomas.—p. 337.
Psychiatric Casualties in Combat. H. H. Garner.—p. 343.
Reactive Depression: Study of 100 Consecutive Cases. H. J. Myers and S. Von Koch.—p. 358.
Psychogenic Disorders of Upper Gastrointestinal Tract in Combat Personnel. E. A. Weinstein and M. H. Stein.—p. 365.
Disease and Defects in Aircrew Trainees: Visual System. O. M. Marchman Jr.—p. 371.
Early Treatment of Open Head Wounds. J. F. Grunnagle.—p. 376.
Familial Periodic Paralysis: Report on Father and Son in World Wars I and II. J. W. Johnson Jr.—p. 382.
Histamine Flare in Evaluation of Peripheral Nerve Lesions. B. Tolnick and W. C. Beck.—p. 386.
Types of Shigella Isolated from Military Personnel in North Africa. C. C. Randall and H. O. Dunn.—p. 389.

Quinacrine Hydrochloride as Malaria-Suppressive Agent.—According to Duncan, quinacrine hydrochloride in doses of 0.1 Gm. daily, six days a week, secures average concentrations in the plasma of 22 micrograms per liter. These concentrations protect subjects against acute attacks of malaria, but they are an irreducible minimum for safety. The omission of an occasional dose permits a clinical attack of malaria to develop in personnel infected with Plasmodium vivax malaria. In the search for the optimum dosage of quinacrine hydrochloride it was observed that 0.5 Gm. of the drug given twice a week was highly effective in suppressing malaria and gave highly protective plasma quinacrine levels. Equally satisfactory results were obtained with 0.4 Gm. twice weekly, whereas the same degree of protection was not offered by 0.3 Gm. of quinacrine hydrochloride given twice a week. Recurrent attacks of malaria reappeared from two to four weeks after the discontinuance of suppressive therapy and at a rate quite as high as that which had preceded a three month period of intensive suppression. When supervision of its daily administration is faithfully exercised, quinacrine hydrochloride in doses of 0.1 Gm. given daily for six days a week is a satisfactory malaria suppressive agent. Adequate supervision of the daily administration of the drug to troops in combat has proved to be impossible. Under these conditions 0.4 Gm. of quinacrine hydrochloride given twice weekly at three and four day intervals alternately provides the optimum dosage and reduces the need of supervised administration of the drug to a minimum.

Hemolytic Streptococcus Carriers in Hospital Personnel.—The bacterial flora of the throats of 44 subjects was observed during the winter and spring of 1944 and 1945. Four groups are differentiated. Those of the first were free from hemolytic streptococcus, whereas in the other three increasingly large numbers were found. Treatment of the hemolytic streptococcus carriers with sulfadiazine seemed to reduce the number of streptococci resident in the throats of carriers materially, but the streptococci reappear after the termination of therapy. A dangerous carrier state is reduced and perhaps controlled only as long as the sulfonamide compound is present in the blood. Harrison and Miller suggest the possibility of a greater efficacy of small doses of a sulfonamide administered over a longer period.

Yale Journal of Biology and Medicine, New Haven

18:77-128 (Dec.) 1945

Streptococcus Fecalis Bacteremia and Meningitis: Report of Case Cured with Penicillin. A. J. Geiger and L. Greenman.—p. 77.
Agglutination of Staphylococcus Aureus in Presence of Normal or Influenza Virus Infected Mouse Lung Filtrates and of Chorioallantoic Fluids. E. W. Shrigley.—p. 81.
Sturge-Weber Syndrome: Report of 3 Cases. H. C. Anderson.—p. 103.
Development of Amnion and Exocoelomic Membrane in Previllous Human Ovum. A. T. Hertig.—p. 107.
Relation Between Discharge Zone and Subliminal Fringe in Motoneuron Pool Supplied by Homogeneous Presynaptic Pathway. D. P. C. Lloyd.—p. 117.

18:129-226 (Jan.) 1946

Amateur in Medical History. I. Galdston.—p. 129.
Effects of Calcium Chloride and of Calcium Lactate Administered by Gavage. S. H. Durlacher, W. Harrison Jr. and D. C. Darrow.—p. 135.
Genetic Analysis of Induction of Tumors by Methylcholanthrene: XII. Effects of Selection Toward Resistance. L. C. Strong.—p. 145.
Pharmacologic Activity of Basic Alkyl Esters of Substituted Pyrrolidine Dicarboxylic Acids: I. Local Anesthetic Activity and Toxicity. N. K. Schaffer and T. A. Loomis.—p. 157.
Local Anesthetic Activity and Toxicity of DI-(Beta-Diethylaminoethyl) Ester of 1-Benzyl 2, 5-Dicarboxy Pyrrolidine. T. A. Loomis and Ruth Spielmeyer.—p. 165.
Pharmacologic Activity of Basic Alkyl Esters of Substituted Pyrrolidine Dicarboxylic Acids: II. Action on Intestine, Uterus and Blood Pressure. T. A. Loomis and N. K. Schaffer.—p. 171.
Taxonomic Studies on Enterococci. R. L. Kuehner.—p. 185.
Delayed Diagnosis in Tubal Abortion: Report of 2 Cases. M. S. Godfried.—p. 217.
*Streptomycin in Tuberculous Meningitis: Report of Its Use in One Year Old Infant. R. E. Cooke, D. L. Dunphy and F. G. Blake.—p. 221.

Streptomycin in Tuberculous Meningitis.—Cooke and his co-workers report that a girl aged 1 year with tuberculous meningitis gave a history of intimate exposure to tuberculosis. A pulmonary lesion and a positive tuberculin test were demonstrated. The cerebrospinal fluid showed characteristic chemical and cytologic changes. Smears showed many acid fast bacilli. Guinea pig inoculation produced the typical disease in five weeks, and the organisms were present in the lesions. Treatment with streptomycin began on the eighth hospital day. It was administered intramuscularly in an amount of 10,000 units in 1 cc. of isotonic solution of sodium chloride every two hours for the first week; 20,000 units was then given every two hours for thirty days. Because of lack of the drug, treatment was interrupted almost seven days. When therapy was resumed the dosage of 20,000 units every two hours was continued for an additional twenty-nine days. The total amount of streptomycin given by intramuscular administration was 15,049,000 units over a period of sixty-eight days. The initial daily amount of streptomycin given intrathecally was 1,000 units. This was gradually increased to 100,000 units by the fifteenth day of therapy. Two hundred thousand units in 5 cc. of isotonic solution of sodium chloride was given intraventricularly every other day commencing on the nineteenth day of treatment. Since the supply of streptomycin was becoming low the amount was decreased to 100,000 units. There was a lapse of nine days in intrathecal administration, but treatment was resumed with 200,000 units every other day over a period of twenty-nine days. The total amount of intrathecal streptomycin was 4,951,000 units. The infant thus received a total of 20,000,000 units by the combined routes. The progression of tuberculous meningitis was arrested during treatment with streptomycin. The symptoms have decreased further since cessation of treatment. There is evidence that intramuscular and intrathecal streptomycin favorably influenced the course of tuberculous meningitis in this patient. This is the first detailed report of the administration of streptomycin by the intrathecal route.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Ophthalmology, London

30:1-64 (Jan.) 1946

Clinical Trial of Synthetic Mydriatic (Dimethylaminoethyl Benzilate Ethochloride). W. J. B. Riddell.—p. 1.
New Synthetic Mydriatic. I. Mann.—p. 8.
Ocular Findings in Tropical Typhus (Tsutsugamushi or Japanese River Fever). E. A. Donegan.—p. 11.
Types, Paper and Printing in Relation to Eyestrain. R. B. Fishenden. —p. 20.
Ophthalmic Treatment in the Field, 1943. G. C. Dansey-Browning. —p. 26.
Cavernous Hemangioma of Orbit Successfully Removed by Shugrue's Operation. M. Paul.—p. 35.
Analysis and Follow-Up of 301 Cases of Battle Casualty Injury to Eyes. G. I. Scott and I. C. Michaelson.—p. 42.

Lancet, London

1:77-112 (Jan. 19) 1946

*Bread. R. A. McCance.—p. 77.
Synergic Action of Penicillin and Sulfathiazole on Bacterium Typhosum. J. W. Bigger.—p. 81.
Hyperventilation Asthma. H. Herxheimer.—p. 83.
*Local Penicillin for Throat Infections. R. G. S. Meadley and H. F. Barnard.—p. 87.
*Human Pulmonary Tuberculosis Due to Avian Tubercle Bacilli: Report of Case. F. C. S. Bradbury and J. A. Young.—p. 89.
Control of Sonne Dysentery with Succinylsulfathiazole. R. L. Vollum and J. A. H. Wylie.—p. 91.
Dengue Group of Fevers in India. P. V. Karamchandani.—p. 92.
Gunshot Wound of Both Orbits: Report of Case. D. L. Charters.—p. 93.

Bread.—McCance points out that there are many substances of proved nutritional value in the outer endosperm and germ of the wheat grain. The inner endosperm is poor stuff nutritionally, and its poverty is enhanced by the fact that its protein is known to contain an unbalanced and incomplete mixture of amino acids. Experience and experiments with animals fully bear out this chemical evidence. A table shows what happens to the composition of flours as the extraction rates are lowered. Changes are due to the gradual removal of the bran, outer endosperm and germ. By 85 per cent extraction most of the bran has gone, and this has led to the big fall in minerals, but most of the germ and scutellum have been retained, with some of the outer endosperm. This has prevented serious fall in vitamin B_1 and has held up the concentration of iron and other vitamins. A big fall in vitamin B_1 occurs as the extraction falls from 85 to 75 per cent, because it is between these two extractions that the germ and scutellum are removed. The inclusion of bran in the flour lowers the utilizable calories of bread, so that raising the extraction rate indefinitely is not all pure gain. Up to 85 per cent the rate of utilization does not fall off much. Flour must in future conform to certain nutritional standards, and these shall be of the order of those contained in flours of 80 to 85 per cent extraction. Everything that we know about biology and nutrition is opposed to the practice of artificial enrichment. Synthetic vitamins and vitamin concentrates are expedients that cannot form the basis for sound nutrition. Good nutrition must be built on a foundation of an optimum diet of natural foodstuffs.

Local Penicillin for Throat Infections.—Meadley and Barnard report a study of the effectiveness of local therapy in cases of acute tonsillitis due to hemolytic streptococci or Vincent's angina. Twenty-seven patients were treated with a penicillin sulfathiazole snuff containing 1,000 units of penicillin per dose and 30 controls with gargles and throat sedatives. A more rapid relief of symptoms and a shorter period off duty was obtained in the penicillin treated cases, especially in those with Vincent's angina. Bacteriologically there was a significant improvement in both types of infection through use of the penicillin snuff. Two severe cases, one streptococcic and one of Vincent's angina, which did not respond to local penicillin rapidly improved on systemic penicillin.

Human Pulmonary Tuberculosis Due to Avian Tubercle Bacilli.—Bradbury and Young describe a case of pulmonary tuberculosis in a man aged 59 in whom the causal organism showed most of the criteria of an avian tubercle bacillus. The patient responded to avian tuberculin but not to human tuberculin.

Bruxelles-Médical, Brussels

26:1-52 (Jan. 13) 1946. **Partial Index**

Surgery of Splanchnic Nerve. J. Goethals-Borin.—p. 9.
*Study of Hypovitaminosis C in Aged Persons. M. L. Fastre and M. Geubel.—p. 24.

Hypovitaminosis C in Aged Persons.—Fastre and Geubel studied 216 persons (150 women and 66 men) between the ages of 60 and 85 who lived in an old people's asylum. Intradermal administration of 1/10 cc. of a solution of 80 mg. of dichlorophenol-indophenol per hundred grams was performed. Saturation, maintenance and vitamin C deficiency were manifested in the time required by the ascorbic acid for the decolorization of the reduced indicator solution. Sixty-eight per cent of the women and 85.5 per cent of the men at the refectory, but 30 per cent of the women and 57 per cent of the men at the infirmary presented a vitamin C deficiency. This percentage of deficiency is higher than that usually presented by normal adults and may be explained by the fact that the aged persons eat less fruit and vegetables.

Arch. Argent. de Enf. del Ap. Digest., Buenos Aires

20:203-290 (May-June) 1945

Resection of Fundus in Treatment of Gastroduodenal Ulcer. O. Copello and E. Etala.—p. 203.
*Circumscribed Gastric Hypertrophy. A. J. Señorans and E. F. Lascano. —p. 214.
Diverticula of Colon, with Especial Reference to Acute Processes. I. Goñi Moreno and A. G. Russo.—p. 229.
Necator Americanus: Its Detection by Duodenal Tube in Case of Secondary Anemia. A. D. Cisneros and E. E. Pasqualis.—p. 256.

Circumscribed Gastric Hypertrophy.—Señorans and Lascano present the history of a patient who for a year had symptoms characteristic of ulcer. Pain was localized in the left hypochondrium. Gastric secretion was reduced in amount and low in hydrochloric acid content. The roentgenologic picture suggested a malignant tumor of the greater curvature. Gastroscopy revealed changes in the folds of the fundus and a gastritis. Physiologic studies have demonstrated that the pyloric (antral) mucosa secretes a hormone which stimulates the glands of the fundus. In the case under consideration there was atrophy in the antral region with almost total disappearance of the pyloric glands, which partly explains the achylia. Subtotal gastrectomy was performed when medical treatment proved ineffective and because of the possibility of malignant degeneration. The condition was diagnosed as chronic gastritis.

Revista Chilena de Pediatría, Santiago

16:1033-1112 (Nov.) 1945. **Partial Index**

Prognosis and Treatment of Tuberculosis in Preschool Child. A. Ariztia. —p. 1033.
*Penicillin in Gonococcic Vulvovaginitis in Young Girls. W. Bustamante E.—p. 1071.
*Cerebral Complications of Renal Diseases in Children. C. Pavez. —p. 1082.

Penicillin in Gonococcic Vulvovaginitis.—Bustamante E. reports good results from penicillin therapy in 6 cases of gonococcic vulvovaginitis in girls between the ages of 4 and 11 years. The disease previously was resistant to sulfonamide therapy. In 4 cases penicillin was administered intramuscularly every three hours in doses varying between 3,000 and 5,000 units for five consecutive days. In 2 cases in which the injections were administered for three consecutive days there was a recurrence. The treatment was repeated successfully. Permanent cures have resulted in all 6 cases up to six months after treatment.

Cerebral Complications of Renal Diseases in Children.—According to Pavez the most important neurologic symptoms of progressive chronic nephritis with hypertension in children are those indicating intracranial hypertension (acute headache, acute meningeal symptoms and either visual disorders or amaurosis). The neurologic symptoms subside with the improvement of the renal lesion, if the latter responds favorably to proper therapy. The differential diagnosis between nephritis and meningitis or cerebral tumor is of importance. The prognosis depends on the course of the renal disease. Two cases in children of 10 and 13 years respectively are reported.

Book Notices

Clinical Biochemistry. By Abraham Cantarow, M.D., Professor of Physiological Chemistry, Jefferson Medical College, Philadelphia, and Max Trumper, Ph.D., Lt. Commander, USNR, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md. Third edition. Cloth. Price, $6.50. Pp. 647, with 29 illustrations. Philadelphia & London: W. B. Saunders Company, 1945.

The first edition of this book by Trumper and Cantarow appeared in 1932 under the title Biochemistry in Internal Medicine. While biochemistry has been used more extensively in internal medicine than in any other specialty, its usefulness covers the whole field of medical practice. The present and more appropriate title of Clinical Biochemistry was employed for the second edition, which appeared in 1939. Despite the fact that considerable new material has been added in the present edition, this has been accomplished without increasing the size of the book owing chiefly to economies in resetting the type and to the omission of some laboratory methods.

Quite logically the first three chapters are devoted to carbohydrate, lipid and protein metabolism. These are followed by eight separate but relatively brief chapters covering the metabolism of calcium, inorganic phosphorus, magnesium, iron, sulfur, iodine, sodium, potassium, chloride and phosphatase activity. It would have been more in keeping with the plan of the earlier chapters to include these topics together in one chapter on mineral metabolism. The remaining chapters cover the topics of water balance, acid-base balance, respiratory exchange and basal metabolism, vitamins, diabetes mellitus, renal function, hepatic function, gastric function, pancreatic function, cerebrospinal fluid, pregnancy and lactation, hormone assay and endocrine function, and outlines of chemical abnormalities in various disorders.

In general the various topics are logically and clearly discussed, the relative emphasis being quite evenly balanced. The subject matter and presentation of hepatic function are excellent, and the same may be said of the new chapter on hormone assay and endocrine function. However, a few misleading statements made in the first edition and carried over to the present edition might be mentioned. On page 83 there appears the incorrect statement that "10-15 per cent of the caffeine is converted into uric acid." Concentration ratios of a number of urinary constituents are presented in tabular form on page 347 and further discussed on pages 362 and 365. Unfortunately the assumed blood and urine concentrations in several instances are incorrect, yielding much too low concentration ratios for creatinine and sulfate and too high a ratio for uric acid, thus changing the interpretation which might be placed on these ratios. It probably would have been more in accord with the apparent aims of the text if in the chapter on vitamins greater emphasis had been placed on vitamin deficiency states.

Many improvements are apparent in the present edition. The first edition did not include bibliographic data, but such references were introduced in the second edition and expanded in the present edition, thus making the book more helpful for those who wish to secure detailed information on special topics. The book will be found stimulating and useful both for students of medicine and for physicians who desire a concise and clear presentation of the practical aspects of biochemistry.

Oto-neurologie: Technique et interprétation des examens labyrinthiques. Par Maurice Aubry, laryngologiste de l'Hôpital Bichat. Paper. Price, 200 francs. Pp. 328, with 48 illustrations. Paris: Masson et Cie, 1944.

It is amazing that such an exact and comprehensive work could be published while France was still in the throes of war. Like many other European books, this one is paper covered, but the entire setup is on excellent smooth finish, heavy duty paper printed in readable type. The author recognizes the importance of the aural labyrinth in the equilibrium of man and animals. Otologists have brought much of importance to neurology but have not done a great deal for otology itself. Otologic studies have helped to determine the vestibular function and its connection with pathways to and from the brain. These studies have stimulated neurologic research. The present volume is based on some fifteen years of work in the famous Salpêtrière Hospital, at the bedside, at surgical operation and at necropsy. All these considerations were dependent on a thorough knowledge of neuroanatomy and neurophysiology. All facts were integrated, and conclusions derived from them were as nearly logically correct as is humanly possible to make them. Not much is said of this same kind of work carried out in other countries, and the Germans especially receive little or no credit for the enormous contributions they have made, notably the Vienna school. In wartime this may have been necessary, but in peacetime we shall continue to hope that science has no frontiers. The book is divided into four parts: a study of the anatomy and physiology of the labyrinth and of the central vestibular pathways, technic of the otoneurologic examination, study of the principal central labyrinth signs and synthesis of the various vestibular syndromes. All these divisions are complete in every detail. The otologist or neurologist who can read French will profit greatly from a thorough perusal of this textbook.

Hematology for Students and Practitioners. By Willis M. Fowler, A.B., M.D., Professor of Internal Medicine, University of Iowa, Iowa City. With a chapter by Elmer L. DeGowin, A.B., M.D., Assistant Professor of Internal Medicine, University of Iowa. Cloth. Price, $8. Pp. 499, with 110 illustrations. New York & London: Paul B. Hoeber, Inc., 1945.

This book offers a comprehensive survey of the field of hematology. It is well outlined and makes easy reading but tends to gloss over or omit fine details. It is thus a good book for the student or practitioner but is less suitable for the specialist in hematology or the clinical pathologist. The chapter on blood transfusion is also well organized and easy to read but, like the section on hematology, it often deals in generalities. However, it would be difficult to cover the subject much more completely in a single chapter. It is unfortunate that so recent a book should omit recommendation or reference to the use of acid-citrate-dextrose solution, which is undoubtedly the best preservative available today for storage of whole blood.

Structure and Function of the Human Body. By Ralph N. Baillif, Ph.D., Assistant Professor of Anatomy, Louisiana State University School of Medicine, New Orleans, and Donald L. Kimmel, Ph.D., Associate Professor of Anatomy, Temple University School of Medicine, Philadelphia. Cloth. Price, $3. Pp. 328, with 286 illustrations. Philadelphia, London & Montreal: J. B. Lippincott Company, 1945.

This is intended as a textbook for an introductory course in human anatomy and physiology. Emphasis is on basic principles and on the relationship between structure and function rather than on factual detail. In an introductory chapter an integrating survey is made of the principal anatomic structures and physiologic processes, to acquaint the student with the field. In subsequent chapters the various organ systems are discussed in more detail, and the student is helped to a better understanding of the normal functioning of the organism by the inclusion of important clinical and pathologic data. The illustrations are good; the diagrammatic figures are particularly clarifying and well executed. The authors have successfully correlated morphologic material and functional aspects in an elementary textbook, so that the book achieves its purpose.

A Synopsis of the Diagnosis of the Surgical Diseases of the Abdomen. By John A. Hardy, B.Sc., M.D., F.A.C.S. Second edition. Fabrikoid. Price, $5. Pp. 528, with 100 illustrations. St. Louis: C. V. Mosby Company, 1945.

The general practitioner still sees most patients with abdominal complaints before the surgeon does. This book gives him an excellent work of reference. It covers the field thoroughly, including gynecologic and urologic disease, and contains the essentials necessary toward more complete and earlier diagnosis of intra-abdominal disease. Proper emphasis is placed on thorough history taking and physical examination of the patient, and laboratory aids to diagnosis are thoroughly covered and evaluated. The chapters devoted to the diagnosis of specific disease each contain discussions of etiology, pathology and diagnosis as well as history and physical examination. The new chapters on hypertension and hypoglycemia are interesting. Though this is only a synopsis and not meant to be a textbook, perhaps more emphasis and space should be given to differentiation of organic from functional disease, an ever increasingly important problem in the practice of medicine.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

STILLBIRTH AND THE Rh FACTOR

To the Editor:—**A patient is now pregnant and gives a history of a stillbirth following an easy first labor one year ago. The patient is Rh positive; the patient's husband is Rh negative. Could this be the cause of stillbirth? If so are there any special procedures advisable in her coming labor except to have a suitable donor? What is the prognosis of her present pregnancy?**

M.D., Oklahoma.

ANSWER.—The suggestion that isoimmunization in pregnancy might be the cause of this patient's stillbirth does not seem plausible on clinical grounds, because this mechanism would not ordinarily produce a stillbirth at the first pregnancy unless the patient had been previously sensitized by a blood transfusion or blood injection. This conclusion gains support from the statement that the patient is Rh positive and her husband Rh negative, a combination which rules out the possibility of Rh sensitization, because this can occur only in the reverse combination. There is always the remote possibility of A-B, Hr or some other sensitization. These remote possibilities can be ruled out with certainty only by performing complete grouping, Rh and Hr tests on the patient and her husband, and then testing the patient's serum for its antibody content by the agglutination and conglutination technics (Wiener, A. S.: Rh Factors in Clinical Medicine, *J. Lab. & Clin. Med.* **30**:957 [Nov.] 1945). In cases in which isoimmunization in pregnancy is the cause of a stillbirth there is at present no known method of preventing the recurrence of such a stillbirth by any special treatment during a succeeding pregnancy.

In cases in which a stillbirth is due to isoimmunization in pregnancy the prognosis for future pregnancies depends on the blood type of the husband (homozygous or heterozygous) and the antibody content of the patient's serum. The prognosis in the case under discussion will depend on the cause of the stillbirth during the first pregnancy. If the first pregnancy was due to a constitutional disease such as diabetes or syphilis, then another stillbirth is likely unless proper and vigorous treatment is instituted early in pregnancy. On the other hand, if some accidental factor such as a short umbilical cord or a knotted cord, or a premature separation of the placenta was the reason for the stillbirth, another stillbirth is improbable.

ABNORMAL NOCTURNAL DIURESIS

To the Editor:—**A man aged 51 has been troubled "as long as he can remember" with the necessity of getting up at night to pass the major portion of his urinary output for the twenty-four hours. He is an active person, participating in active sports to a considerable degree. He has had no complaints referable to this difficulty except that he has been informed on various routine examinations that he had an enlarged prostate that would no doubt "cause him trouble some time." On examination the prostate is somewhat enlarged and is quite firm, but it is bilaterally symmetrical and is not tender. About 60 per cent of the average day's output of 61 ounces occurs at night, as much as 60 ounces having been voided at night. An occasional period of rest in the daytime in the reclining position will cause him to void three or more times within an hour, but on arising he may not void again until night. All urinary findings at all times have been normal. The condition is somewhat aggravated by advancing age but has been unchanged, in principle, since childhood. I would appreciate any explanation of this phenomenon.**

M.D., California.

ANSWER.—A history of voiding the major portion of a twenty-four hour urinary output during the night since childhood, without other evidence of organic disease, strongly suggests a functional rather than an organic disturbance. Among the various causes for an abnormally large excretion of urine during the night may be listed nephritis, diabetes insipidus, hypertension and cardiac degeneration or decompensation. Lesions in the lower urinary tract, such as prostatic enlargement with or without residual urine, and some forms of cystitis may cause predominant urinary frequency at night. All of these lesions can be excluded in this case, since they could hardly extend back to childhood without other clinical abnormalities. A habit forming type of urinary frequency is sometimes observed, but the symptoms are not usually confined to night time.

The desire to urinate is supposed to be implemented by relaxation of the bladder neck, permitting urine to reach the prostatic urethra. The fact that when this patient assumes a reclining position in a rest period during the day he finds it necessary to void three or four times within an hour and is relieved by arising would suggest the possibility of relaxation of the bladder neck when in the dorsal position so as to permit the escape of urine into the prostatic urethra. There are various lesions at the neck of the bladder which might cause such symptoms when the patient is in a reclining position. Included in this group are deformities of the bladder neck such as contraction and so-called valves. Relaxation of the prostatic urethra sometimes is observed which may be secondary to obscure lesions affecting the nerve supply of the bladder neck.

In order to determine the exact condition present, cystourethroscopy would be quite essential. It would be of interest to ascertain the presence of any residual urine. A plain roentgenogram and an excretory urogram also are indicated. In fact, in this case the exact diagnosis would hinge largely on a thorough urologic examination. If all such data are negative, the conclusion would necessarily be that the symptoms are of a functional nature, in which event the patient should be instructed to limit his fluid intake after 5 p. m.

CARCINOMA OF THE PROSTATE

To the Editor:—**In April 1945 a roentgenogram accidentally disclosed osteoclastic bone metastases in the pelvis of a man aged 60. Subsequently the diagnosis of carcinoma of the prostate was made by a urologist. Since that time he has been taking 3 mg. of diethylstilbestrol daily. X-ray films in September showed no spreading of the bone lesions and regression in some of them. He is gaining weight. His red blood cell count in May was 3,300,000; it now is 4,250,000. He is working. The prostate is enlarged with an irregular surface but is rather soft. Lately there has been a slight whitish urethral discharge. A smear was negative for gonococci. The sediment of the urine shows an increased number of leukocytes but no erythrocytes. He has had a mild diabetes controlled by diet for several years. Is the treatment described adequate or would any other be advisable at this stage?**

M.D., Illinois.

ANSWER.—The history given is typical of a carcinoma of the prostate gland with bone metastases to the pelvis. The results obtained by estrogenic substance are what one should expect in 60 per cent of the cases or more. The dosage given appears to be adequate but usually the tolerance dose needed, over a long period, is 2 mg. daily. However, the tendency has been lately, all over the country, to use enormous doses of diethylstilbestrol such as 15 to 20 mg. a day in divided doses. Whether or not this is advantageous no one can state at this time. If back pains or leg pains or other evidence of deep metastasis present themselves, bilateral orchiectomy may have to be tried.

HODGKIN'S DISEASE

To the Editor:—**Will you please discuss the treatment of Hodgkin's disease?**

M.D., New York.

ANSWER.—The treatment of choice for Hodgkin's disease is irradiation. Relatively small doses are given to the involved glands. This usually causes a regression in size of the nodes and an improvement in general well being. Irradiation is repeated when the enlarged nodes recur or when previously uninvolved nodes become involved. There comes a time when irradiation no longer causes regression of nodes and improvement in the general condition: general deterioration and fatality ensue. The usual course of Hodgkin's disease, well managed by irradiation, is three to five years, in some instances shorter, and in the occasional case palliation may obtain for ten years or even longer. According to some, when a patient is first seen presenting only one group of nodes involved, better results are secured if that group is resected and x-rays are given to the area postoperatively, also to the other nodes in the adjacent regions. If more than one large group of nodes is involved when the patient is first seen, the question of excision does not arise.

HEMOGLOBIN SOLUTION

To the Editor:—**I am using a Leitz colorimeter and the company advises that the hemoglobin solution 0.1 per cent solution sodium carbonate be made up fresh every sixty days. I have been advised to obtain solution direct from the Leitz company. Would it be all right for my own druggist to make up this solution every two to four weeks? Would there be enough difference in the solutions to change the hemoglobin readings?**

M.D., Minnesota.

ANSWER.—A 0.1 per cent solution of sodium carbonate correctly made by a druggist should be just as satisfactory for hemoglobin determination as one obtained from a commercial company. The sodium carbonate used should be chemically pure.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY—APRIL 1946

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1933. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta chirurgica Scandinavica. Stockholm.
Acta dermato-venereologica. Stockholm.
Acta medica scandinavica. Stockholm.
Acta radiologica. Stockholm.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Cincinnati.
American Journal of Orthodontics and Oral Surgery. St. Louis.
American Journal of Orthopsychiatry. New York.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield. Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
American Review of Soviet Medicine. New York.
American Review of Tuberculosis. New York.
Anesthesiology. New York.
Annales pædiatrici. Basel.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Annals of Tropical Medicine and Parasitology. Liverpool.
*Archives of Dermatology and Syphilology. A. M. A., Chicago.
Archives of Disease in Childhood. London.
Archives francaises de pédiatrie. Paris
*Archives of Internal Medicine. A. M. A., Chicago.
Archives des Maladies du cœur. Paris.
*Archives of Neurology and Psychiatry. A. M. A., Chicago.
*Archives of Ophthalmology. A. M. A., Chicago.
*Archives of Otolaryngology. A. M. A., Chicago.
*Archives of Pathology. A. M. A., Chicago.
Archives of Physical Medicine. Chicago.
*Archives of Surgery. A. M. A., Chicago.
Archivos argentinos de enfermedades del aparato digestivo y de la nutrición. Buenos Aires.
Archivos de pediatría del Uruguay. Montevideo.
Arizona Medicine. Phoenix
Australian Journal of Experimental Biology & Medical Science. Adelaide.
Australian and New Zealand Journal Surgery. Sydney.
Boletín de la Oficina sanitaria panamericana. Washington, D. C.
Brain. London.
British Heart Journal London.
British Journal of Dermatology and Syphilis. London.
British Journal of Experimental Pathology. London.
British Journal of Industrial Medicine. London.
British Journal of Ophthalmology. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Tuberculosis. London.
British Journal of Urology. London.
British Medical Journal. London.
Bruxelles-Médical. Brussels.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Los Angeles Neurological Society. Los Angeles.
Bulletin of the New York Academy of Medicine. New York.
Bulletin of the U. S. Army Medical Department. Washington, D. C.
California and Western Medicine. San Francisco.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer Research. Baltimore.
Cardiologia. Basel.
Chinese Medical Journal. Washington, D. C.
Cincinnati Journal of Medicine. Cincinnati.
Confinia neurologica. Basel.
Connecticut State Medical Journal. Hartford.
Delaware State Medical Journal. Wilmington.
Día médico. Buenos Aires.
Diseases of Chest. Chicago
Edinburgh Medical Journal.
Endocrinology. Springfield, Ill.
Epidemiological Information Bulletin. Washington, D. C.
Experimental Medicine and Surgery. Brooklyn.
Gastroenterology. Baltimore.
Hawaii Medical Journal. Honolulu.
Hospital. Rio de Janeiro.
Illinois Medical Journal. Chicago.
Industrial Medicine. Chicago.
Irish Journal of Medical Science. Dublin.
Journal of Allergy. St. Louis.
Journal of the Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal of Bone and Joint Surgery. Boston.
Journal of Clinical Endocrinology. Springfield, Ill.
Journal of Clinical Investigation. Boston.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Hygiene. London.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Industrial Hygiene and Toxicology. Baltimore.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Kansas Medical Society. Topeka.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal of Laryngology and Otology. London.
Journal-Lancet Minneapolis.
Journal of the Maine Medical Association. Portland.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of Mental Science. London.
Journal of the Michigan State Medical Society. Lansing.
Journal of the Missouri State Medical Association. St. Louis.
Journal of the Mount Sinai Hospital. New York.
Journal of the National Cancer Institute. Washington, D. C.
Journal National Malaria Society. Tallahassee, Fla.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology, Neurosurgery and Psychiatry. London.
Journal of Neuropathology and Experimental Neurology. Baltimore.
Journal of Neurophysiology. Springfield, Ill.
Journal of Neurosurgery. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of British Empire. Manchester.
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of Physiology. Cambridge
Journal of the South Carolina Medical Association. Florence.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Urology. Baltimore.
Kentucky Medical Journal. Bowling Green.
Khirurgiya, Moscow.
Lancet. London.
Laryngoscope. St. Louis.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina. Madrid.
Medicine. Baltimore.
Military Surgeon. Washington, D. C.
Minnesota Medicine. St. Paul.
Monatsschrift für Geburtshilfe und Gynäkologie, Basel.
Monatsschrift für Psychiatrie and Neurologie. Basel.
Nebraska State Medical Journal. Lincoln.
New England Journal of Medicine. Boston.
New Orleans Medical and Surgical Journal.
New York State Journal of Medicine. New York.
New Zealand Medical Journal. Wellington.
Nordisk medicin. Gothenburg.
North Carolina Medical Journal. Winston-Salem.
Northwest Medicine. Seattle.

*Cannot be lent.

Ohio State Medical Journal. Columbus.
Ophthalmologica. Basel.
Pennsylvania Medical Journal. Harrisburg.
Physiological Reviews. Baltimore.
Policlinico (sezione medica). Rome.
Practica oto rhino-laryngologica. Basel.
Practitioner. London.
Praxis. Bern.
Prensa Médica Argentina. Buenos Aires.
Presse médicale. Paris.
Proceedings of Royal Society of Medicine. London.
Proceedings of the Staff Meetings of the Mayo Clinic. Rochester, Minn.
Progrès médical. Paris.
Psychoanalytic Quarterly. Albany, N. Y.
Psychosomatic Medicine. Baltimore.
Public Health Reports Washington, D. C.
Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Review of Gastroenterology. New York
Revista chilena de pediatría. Santiago.
Revista médica de Chile. Santiago.
Revista médica de Costa Rica. San José.
Revue belge des sciences médicales. Louvain.
Rhode Island Medical Journal. Providence.
Rocky Mountain Medical Journal. Denver.
Schweizerische Zeitschrift für Pathologie und Bakteriologie. Basel.
Semana Médica. Buenos Aires.
Semaine des Hôpitaux de Paris. Paris.
South African Journal of Medical Sciences. Johannesburg.
South African Medical Journal. Cape Town.
Southern Medical Journal. Birmingham, Ala.
Surgery. St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Texas State Journal of Medicine. Fort Worth.
Transactions of the Royal Society of Tropical Medicine and Hygiene. London.
Tubercle. London.
Union Médicale du Canada. Montreal.
United States Naval Medical Bulletin. Washington, D. C.
Urologic and Cutaneous Review. West Palm Beach, Fla.
Virginia Medical Monthly. Richmond.
*War Medicine. A. M. A., Chicago.
Western Journal of Surgery Obstetrics and Gynecology. Portland, Ore.
West Virginia Medical Journal. Charleston.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts and "Societies" are indexedunder these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy *Indust.—Industrial*
Am.—American *Inst.—Institute*
A.—Association *Internat.—International*
Coll.—College *M.—Medical*
Commn.—Commission *Med.—Medicine*
Comm.—Committee *Nat.—National*
Conf.—Conference *Pharm.—Pharmaceutical*
Cong.—Congress *Phys.—Physicians*
Dist.—District *Soc.—Society*
Div.—Division *Surg.—Surgery*
Found.—Foundation *Surgs.—Surgeons*
Hosp.—Hospital *S.—Surgical*

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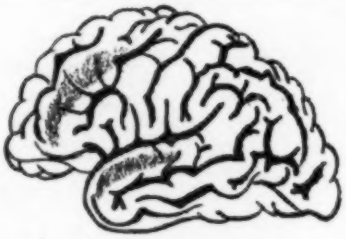

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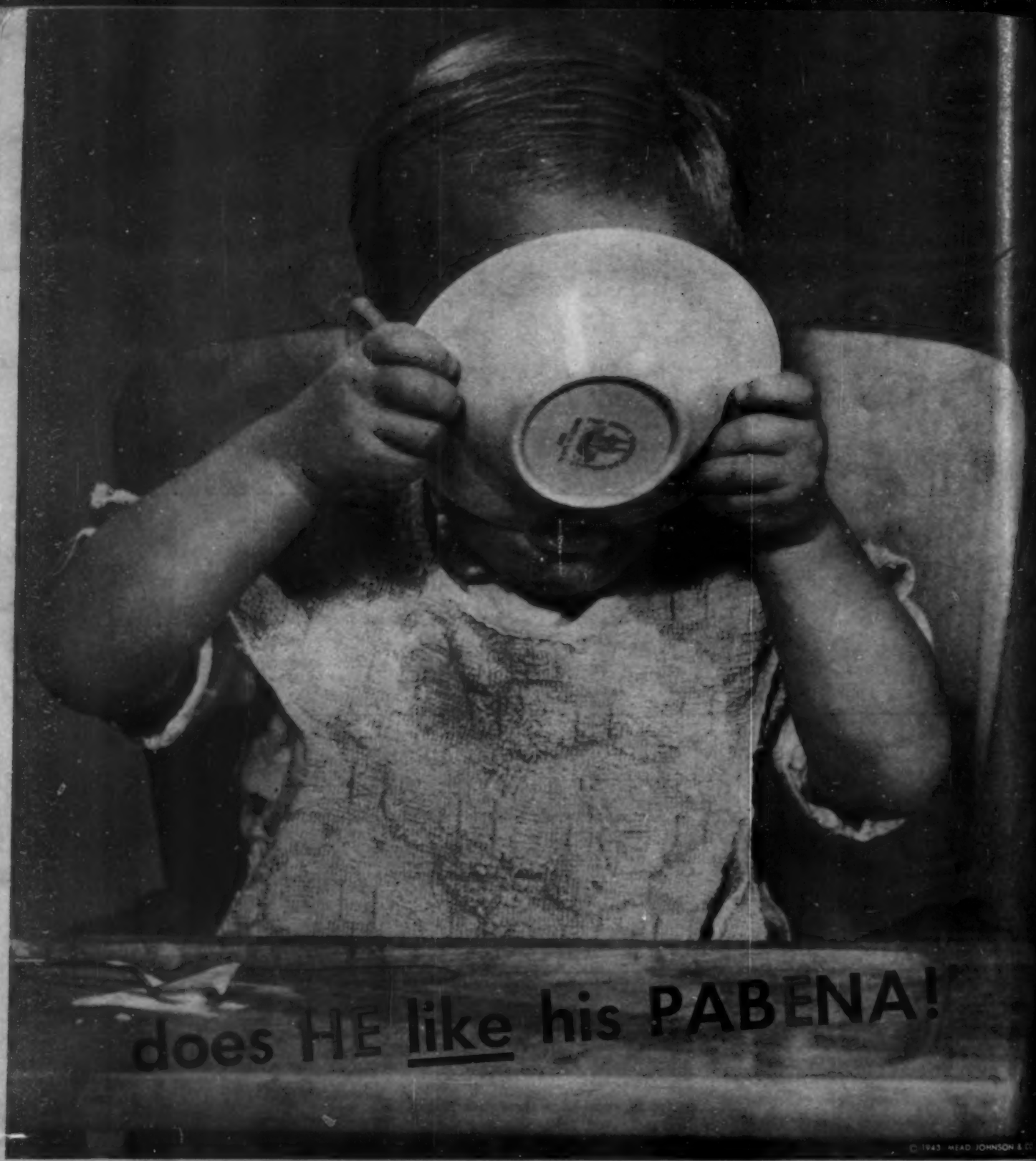

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